


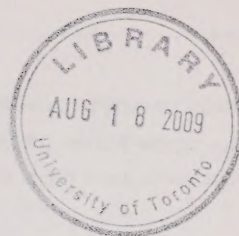


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Second Session
Fortieth Parliament, 2009

Deuxième session de la
quarantième législature, 2009

SENATE OF CANADA

SÉNAT DU CANADA

*Standing Senate Committee on Social Affairs,
Science and Technology*

*Comité sénatorial permanent des Affaires sociales,
des sciences et de la technologie*

Proceedings of the Subcommittee on

Délibérations du Sous-comité sur la

Population Health

Santé des populations

Chair:

The Honourable WILBERT J. KEON

Président :

L'honorable WILBERT J. KEON

Wednesday, April 1, 2009
Thursday, May 7, 2009 (in camera)
Wednesday, May 27, 2009 (in camera)

Le mercredi 1^{er} avril 2009
Le jeudi 7 mai 2009 (à huis clos)
Le mercredi 27 mai 2009 (à huis clos)

**Issue No. 4
(Volume 1 of 3)**

**Fascicule n° 4
(Volume 1 de 3)**

**Ninth, tenth and eleventh (last)
meetings on:**

The impact of the multiple factors and conditions that
contribute to the health of Canada's populations —
known collectively as the determinants of health

**Neuvième, dixième et onzième (dernière)
réunions concernant :**

Les divers facteurs et situations qui contribuent
à la santé de la population canadienne, appelés
collectivement les déterminants de la santé

INCLUDING:
THE SECOND REPORT OF THE SUBCOMMITTEE
(*A Healthy, Productive Canada:
A Determinant of Health Approach*)
(Eighth Report of Standing Senate Committee on Social
Affairs, Science and Technology)

Y COMPRIS :
LE DEUXIÈME RAPPORT DU SOUS-COMITÉ
(*Un Canada en santé et productif :
une approche axée sur les déterminants de la santé*)
(Le huitième rapport du Comité sénatorial permanent des
Affaires sociales, des sciences et de la technologie)

WITNESSES:
(See back cover)

TÉMOINS :
(Voir à l'endos)

THE SUBCOMMITTEE ON POPULATION HEALTH

The Honourable Wilbert J. Keon, *Chair*

The Honourable Lucie Pépin, *Deputy Chair*

and

The Honourable Senators:

Callbeck
Champagne, P.C.
Cook

Eaton
Fairbairn, P.C.

(Quorum 3)

Changes in membership of the subcommittee:

Pursuant to rule 85(4), membership of the subcommittee was amended as follows:

The Honourable Senator Champagne, P.C., replaced the Honourable Senator Stratton (*March 30, 2009*).

The Honourable Senator Stratton replaced the Honourable Senator Champagne, P.C. (*March 27, 2009*).

LE SOUS-COMITÉ SUR LA SANTÉ DES POPULATIONS

Président : L'honorable Wilbert J. Keon

Vice-présidente : L'honorable Lucie Pépin

et

Les honorables sénateurs :

Callbeck
Champagne, C.P.
Cook

Cook
Fairbairn, C.P.

(Quorum 3)

Modifications de la composition du sous-comité :

Conformément à l'article 85(4) du Règlement, la liste des membres du sous-comité est modifiée, ainsi qu'il suit :

L'honorable sénateur Champagne, C.P., a remplacé l'honorable sénateur Stratton (*le 30 mars 2009*).

L'honorable sénateur Stratton a remplacé l'honorable sénateur Champagne, C.P. (*le 27 mars 2009*).

MINUTES OF PROCEEDINGS

OTTAWA, Wednesday, April 1, 2009
(10)

[English]

The Senate Subcommittee on Population Health met this day at 4:14 p.m., in room 2, Victoria Building, the chair, the Honourable Wilbert J. Keon, presiding.

Members of the committee present: The Honourable Senators Callbeck, Cook, Eaton, Fairbairn, C.P., Keon and Pépin (6).

Other senators present: The Honourable Senators Eggleton, P.C., and Stratton (2).

In attendance: Odette Madore, Acting Chief, Social, Health and Cultural Section, Social Affairs Division, Parliamentary Information and Research Service, Library of Parliament.

Also in attendance: The official reporters of the Senate.

Pursuant to the order of reference adopted by the Senate on Tuesday, February 24, 2009, the subcommittee continued its examination on population health. (*For complete text of the order of reference, see proceedings of the committee, Issue No. 1.*)

WITNESSES:

Champlain Local Health Integration Network:

Dr. Robert Cushman, Chief Executive Officer.

BC Healthy Communities:

Jodi Mucha, Director.

As an individual:

Dr. Kellie Leitch.

The chair made a opening statement.

Dr. Cushman and Ms. Mucha made a presentation and answered questions.

At 5:38 p.m., the committee suspended.

At 6:10 p.m., the committee resumed.

Dr. Leitch made a presentation and answered questions.

At 6:57 p.m., it was agreed that the subcommittee adjourn to the call of the chair.

ATTEST:

PROCÈS-VERBAUX

OTTAWA, le mercredi 1^{er} avril 2009
(10)

[Traduction]

Le Sous-comité sénatorial sur la santé des populations se réunit aujourd'hui à 16 h 14 dans la salle 2 de l'édifice Victoria, sous la présidence de l'honorable Wilbert J. Keon (*président*).

Membres du comité présents : Les honorables sénateurs Callbeck, Cook, Eaton, Fairbairn, C.P., Keon et Pépin (6).

Autres sénateurs présents : Les honorables sénateurs Eggleton, C.P. et Stratton (2).

Également présente : Odette Madore, directrice principale par intérim, Section des affaires sociales, culturelles et de la santé, Division des affaires sociales, Service d'information et de recherche parlementaires, Bibliothèque du Parlement.

Aussi présents : Les sténographes officiels du Sénat.

Conformément à l'ordre de renvoi adopté par le Sénat le mardi 24 février 2009, le comité poursuit son étude sur la santé des populations. (*Le texte intégral de l'ordre de renvoi figure au fascicule n^o 1 des délibérations du sous-comité.*)

TÉMOINS :

Réseau local d'intégration des services de santé de Champlain :

Dr Robert Cushman, directeur général.

B.C. Healthy Communities :

Jodi Mucha, directrice.

À titre personnel :

Dre Kellie Leitch.

Le président fait une déclaration.

Le Dr Cushman et Mme Mucha font un exposé, puis répondent aux questions.

À 17 h 38, le comité suspend ses travaux.

À 18 h 10, le comité reprend ses travaux.

La Dre Leitch fait un exposé, puis répond aux questions.

À 18 h 57, il est convenu que le sous-comité suspende ses travaux jusqu'à nouvelle convocation de la présidence.

ATTESTÉ :

OTTAWA, Thursday, May 7, 2009

(11)

[English]

The Subcommittee on Population Health met, in camera this day at 10:46 a.m., in room 705, Victoria Building, the chair, the Honourable Wilbert J. Keon, presiding.

Members of the committee present: The Honourable Senators Champagne, P.C., Cook, Eaton, Fairbairn, C.P., Keon and Pépin (6).

In attendance: Odette Madore, Acting Chief, Social, Health and Cultural Section, Social Affairs Division, Parliamentary Information and Research Service, Library of Parliament and Michael Toye, Research staff.

Also in attendance: The official reporters of the Senate.

Pursuant to the order of reference adopted by the Senate on Tuesday, February 24, 2009, the subcommittee continued its examination on population health. (*For complete text of the order of reference, see proceedings of the committee, Issue No. 1.*)

Pursuant to rule 92(2)(f), the committee considered a draft report.

At 11:28 a.m., it was agreed that the subcommittee adjourn to the call of the chair.

ATTEST:

OTTAWA, Wednesday, May 27, 2009

(12)

[English]

The Subcommittee on Population Health met, in camera this day at 4:20 p.m., in room 705, Victoria Building, the chair, the Honourable Wilbert J. Keon, presiding.

Members of the committee present: The Honourable Senators Callbeck, Champagne, P.C., Cook, Fairbairn, C.P., Keon and Pépin (6).

Other senators present: The Honourable Senators Eggleton, P.C., and Segal (2).

In attendance: Odette Madore, Acting Chief, Social, Health and Cultural Section, Social Affairs Division and Havi Echenberg, Analyst, Parliamentary Information and Research Service, Library of Parliament.

OTTAWA, le jeudi 7 mai 2009

(11)

[Traduction]

Le Sous-comité sur la santé des populations se réunit aujourd'hui à huis clos, à 10 h 46, dans la salle 705 de l'édifice Victoria, sous la présidence de l'honorable Wilbert J. Keon (*président*).

Membres du comité présents : Les honorables sénateurs Champagne, C.P., Cook, Eaton, Fairbairn, C.P., Keon et Pépin (6).

Également présents : Odette Madore, directrice principale par intérim, Section des affaires sociales, culturelles et de la santé, Division des affaires sociales, Service d'information et de recherche parlementaires, Bibliothèque du Parlement, et Michael Toye, attaché de recherche.

Aussi présents : Les sténographes officiels du Sénat.

Conformément à l'ordre de renvoi adopté par le Sénat le mardi 24 février 2009, le sous-comité poursuit son étude sur la santé des populations. (*Le texte intégral de l'ordre de renvoi figure au fascicule n° 1 des délibérations du comité.*)

Conformément à l'article 92(2)f), le comité examine une ébauche de rapport.

À 11 h 28, il est convenu que le sous-comité suspende ses travaux jusqu'à nouvelle convocation de la présidence.

ATTESTÉ :

OTTAWA, le mercredi 27 mai 2009

(12)

[Traduction]

Le Sous-comité sur la santé des populations se réunit aujourd'hui à huis clos, à 16 h 20, dans la salle 705 de l'édifice Victoria, sous la présidence de l'honorable Wilbert J. Keon (*président*).

Membres du comité présents : Les honorables sénateurs Callbeck, Champagne, C.P., Cook, Fairbairn, C.P., Keon et Pépin (6).

Autres sénateurs présents : Les honorables sénateurs Eggleton, C.P. et Segal (2).

Également présentes : Odette Madore, directrice principale par intérim, Section des affaires sociales, culturelles et de la santé, Division des affaires sociales, et Havi Echenberg, analyste, Service d'information et de recherche parlementaires, Bibliothèque du Parlement.

Pursuant to the order of reference adopted by the Senate on Tuesday, February 24, 2009, the subcommittee continued its examination on population health. (*For complete text of the order of reference, see proceedings of the committee, Issue No. 1.*)

Pursuant to rule 92(2)(f), the subcommittee considered a draft report.

It was agreed, that the subcommittee adopt the draft report entitled: *A Healthy, Productive Canada: A Determinant of Health Approach* and that the Subcommittee on Agenda and Procedure be empowered to make minor editorial changes required prior to tabling the report in the Senate.

At 4:30 p.m., it was agreed that the subcommittee adjourn to the call of the chair.

ATTEST:

La greffière du sous-comité,

Keli Hogan

Clerk of the Subcommittee

Conformément à l'ordre de renvoi adopté par le Sénat le mardi 24 février 2009, le sous-comité poursuit son étude sur la santé des populations. (*Le texte intégral de l'ordre de renvoi figure au fascicule n° 1 des délibérations du comité.*)

Conformément à l'article 92(2)f), le sous-comité examine une ébauche de rapport.

Il est convenu que le sous-comité adopte l'ébauche de rapport intitulée *Un Canada en santé et productif : une approche axée sur les déterminants de la santé* et que le Sous-comité du programme et de la procédure soit autorisé à y apporter les modifications de pure forme nécessaires avant son dépôt au Sénat.

À 16 h 30, il est convenu que le sous-comité suspende ses travaux jusqu'à nouvelle convocation de la présidence.

ATTESTÉ :

REPORT OF THE COMMITTEE

Wednesday, June 3, 2009

The Standing Senate Committee on Social Affairs, Science and Technology has the honour to table its

EIGHTH REPORT

Your committee, which was authorized by the Senate on Tuesday, February 24, 2009, to examine and report on the impact of the multiple factors and conditions that contribute to the health of Canada's population, now tables its final report entitled *A Healthy, Productive Canada: A Determinant of Health Approach*.

Respectfully submitted,

Le vice-président,

WILBERT JOSEPH KEON

Deputy Chair

(Text of the report appears following the evidence in this volume.

Text of Appendix A appears in Volume 2.

Text of Appendices B and C appears in Volume 3.)

RAPPORT DU COMITÉ

Le mercredi 3 juin 2009

Le Comité sénatorial permanent des Affaires sociales, des sciences et de la technologie a l'honneur de déposer son

HUITIÈME RAPPORT

Votre comité a été autorisé par le Sénat le mardi 24 février 2009 à étudier, afin d'en faire rapport les divers facteurs et situation qui contribuent à la santé de la population canadienne, dépose maintenant son rapport final intitulé *Un Canada en santé et productif: Une approche axée sur les déterminants de la santé*.

Respectueusement soumis,

(Le texte du rapport paraît après les témoignages.

Le texte de l'annexe A paraît au volume 2.

Le texte des annexes B et C paraît au volume 3.)

EVIDENCE

OTTAWA, Wednesday, April 1, 2009

The Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology met this day at 4:14 p.m. to examine and report on the impact of the factors and conditions that contribute to the health of Canada's population — known collectively as the social determinants of health (topic: community-level population health model; and child health).

Senator Wilbert J. Keon (*Chair*) in the chair.

[*English*]

The Chair: Some more senators will be arriving, but we will begin.

We have two outstanding witnesses. We look forward to much information coming forth.

Dr. Cushman, you are going first, I understand.

I have known Dr. Robert Cushman for 30 years. He has had a long-standing career in the public health domain. Even more exciting now is that he is the CEO of the Champlain Local Health Integration Network, which I believe is a great thing for Ottawa.

Dr. Robert Cushman, Chief Executive Officer, Champlain Local Health Integration Network: It is a pleasure to be here. I will try to be short. I notice the questions and the answers. Could they be adapted? The answer is "definitely." Can they be adapted? That is the question mark.

There are some examples out there — the local community services centres, CLSCs, particularly in Quebec; and the community health centres, CHCs, across the country — but we are now in 2009 and we have to update what is out there and perhaps have more. The other question was about having the one-stop-shopping principle and having many resources under one roof. That certainly makes a lot of sense for the consumer, for the clients and the patients, and it also promotes integration amongst the services.

Now that I have answered the questions, I have more time left. I thought I would share with you some of my challenges so that you can better appreciate how this might help. I have titled my talk "Getting Out of Hospital and Closer to Home." It is looking at how we plan clinical services in the Champlain Local Health Integration Network.

There are now 14 local health integration networks, LHINs, in Ontario. I have provided you with a map. In terms of population, health care resources and the academic health science centre, we compare with six of Canada's provinces, not the big four, but with about six in terms of planning.

TÉMOIGNAGES

OTTAWA, le mercredi 1^{er} avril 2009

Le Sous-comité sénatorial sur la santé des populations du Comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui, à 16 h 14, afin de mener une étude sur les divers facteurs et situations qui contribuent à la population de la santé canadienne, appelés collectivement les déterminants de la santé (sujet : la santé des populations au niveau des collectivités; est la santé des enfants).

Le sénateur Wilbert J. Keon (*président*) occupe le fauteuil

[*Traduction*]

Le président : Il y a d'autres sénateurs qui doivent se joindre à nous, mais nous commencerons.

Nous avons deux témoins remarquables. Nous espérons apprendre de nombreuses choses.

Docteur Cushman, vous parlerez en premier, selon ce que j'ai cru comprendre.

Je connais le Dr Robert Cushman depuis 30 ans. Il a eu une longue carrière dans le domaine de la santé publique. Ce qui est encore plus excitant, c'est qu'il est maintenant le directeur général du Réseau local d'intégration des services de santé de Champlain. Je crois que c'est une merveilleuse nouvelle pour Ottawa.

Dr Robert Cushman, directeur général, Réseau local d'intégration des services de santé de Champlain : Je suis heureux d'être ici. J'essaierai d'être bref. J'ai remarqué les questions et les réponses. Pourrait-on les modifier? Définitivement. Peut-on les modifier? Là est la question.

Il existe quelques exemples, tels que des centres locaux de services communautaires, qui se trouvent surtout au Québec, et des centres de santé communautaire, qui se trouvent partout au pays. Toutefois, nous sommes maintenant en 2009, et nous devons mettre à jour ces choses et peut-être mettre en place d'autres services. L'autre question portait sur le principe de guichet unique où de nombreuses ressources pourraient se trouver sous le même toit. Cela serait certainement une solution très logique pour les consommateurs, les clients et les patients, et elle favoriserait l'intégration des services.

Maintenant que j'ai répondu aux questions, il me reste plus de temps. Je pensais partager avec vous quelques-uns des défis que je dois relever afin que vous puissiez mieux comprendre l'utilité de la chose. Ma discussion s'intitule « Sortir de l'hôpital et se rapprocher de chez soi ». Elle concerne la planification des services cliniques au Réseau local d'intégration des services de santé de Champlain.

Il y a maintenant 14 réseaux locaux d'intégration des services de santé (RLISS) en Ontario. Je vous ai fourni une carte. En ce qui concerne la population, les ressources de soins de santé et le centre universitaire des sciences de la santé, nous avons effectué une comparaison avec six des provinces du Canada, et non les quatre grandes provinces, quant à la planification.

As to what we are all about, I have shown you that with the planning piece, the funding and allocation piece, the accountability and performance piece — that wheel you have there. What is interesting here is the community engagement piece, trying to engage the public. As a physician, I always ask people about their chest pain, but I never ask them about their voyage in the system. We have been doing that recently. I can tell you I am getting an earful. This is very helpful. We need to incorporate this as we plan.

As you see, this is what integration looks like. It gives a more seamless experience and improved match between what is provided and what folks need, and hopefully things are more effective and efficient at the end of the day. That is the philosophy.

I have provided you with a pie diagram that shows you where the resources are: 73 per cent are in hospital and 12 per cent in long-term care. That is already 85 per cent in the institutions. Our home care organization is very much a hospital in the home these days. You can probably take about 4 per cent of that and say it is either institutional or acute care service.

My message to you is that we do not have enough resources in the community. We have to shift into the community, away from the institutions. Our budget is over \$2 billion and we have 206 health service providers. In fact, the Ottawa Hospital with the Heart Institute by and large consumes about 55 per cent to 60 per cent of the budget. That gives you an idea of some of the challenges we face.

I have given you our six strategic directions. What could be done in a polyclinic? What could be done in a community? What could be done anywhere and not necessarily in a hospital? Certainly, primary health services could. You notice we call it services, not care, because we understand how rounded it is. It may include snow shovelling or neighbourhood watch, as well as checking cholesterol.

In terms of chronic disease prevention and management, we now have major problems with diabetes and other chronic diseases. Addictions and mental health have been brought out because they are the poor orphan of diseases. We wanted to put mental health and addictions together because there is so much comorbidity, and yet the service providers tend to be in one silo or the other.

I think the elderly with complex conditions are the biggest challenge facing health care today. It is how we take care of people in the last 10 years of their life, and having our resources concentrated in acute care in hospitals is certainly not the way to do it. Of course, eHealth with electronic records is an enabler in health.

J'ai montré qui nous étions en vous présentant la roue que vous avez devant vous et les éléments qui la constituent, à savoir la planification, le financement et la répartition des fonds, ainsi que la reddition de compte et la gestion du rendement. L'élément le plus intéressant de cette roue est l'engagement communautaire, qui vise à communiquer avec le public. En tant que médecin, je demande toujours aux patients de me parler de leurs douleurs thoraciques, mais je ne leur demande jamais de me parler de leurs expériences dans le système. C'est ce que nous faisons récemment. Je peux vous dire que j'apprends beaucoup de choses. C'est très utile. Nous devons intégrer ces commentaires dans la planification.

Comme vous le voyez, c'est cela l'intégration. Cela donne une expérience plus harmonieuse et nous permet de modifier les services pour qu'ils répondent mieux aux besoins des gens. Nous espérons que cela permettra d'améliorer l'efficacité des services au bout du compte. C'est notre philosophie.

Je vous ai fourni un diagramme circulaire qui montre où les ressources sont affectées : 73 p. 100 des ressources sont attribuées aux hôpitaux ; et 12 p. 100, aux soins prolongés. C'est déjà 85 p. 100 des ressources qui sont affectées aux institutions. Notre organisation de soins à domicile est vraiment comme un hôpital à domicile de nos jours. Approximativement 4 p. 100 de ce nombre peut être considéré comme des soins institutionnels ou des soins intensifs de courte durée.

Ce que je veux vous dire, c'est que les communautés n'ont pas assez de ressources. Nous devons nous éloigner des institutions, et nous concentrer sur les communautés. Nous avons un budget de plus de 2 milliards de dollars, et nous avons 206 fournisseurs de services de santé. L'Hôpital d'Ottawa et l'Institut de cardiologie reçoivent entre 55 et 60 p. 100 de ce budget. Cela vous donne une idée des défis auxquels nous sommes confrontés.

Je vous ai donné nos six directions stratégiques. Que pourrait-on fournir dans une polyclinique? Que pourrait-on fournir dans une collectivité? Qu'est-ce qui pourrait être fourni partout, et pas seulement dans un hôpital? On pourrait certainement fournir des services de santé primaires. Veuillez noter que nous parlons de services et non de soins, parce que nous en comprenons l'exhaustivité. En effet, ces services pourraient inclure le déblaiement de la neige ou la surveillance du quartier en plus de la vérification du cholestérol.

Pour ce qui est de la prévention et de la gestion des maladies chroniques, nous avons maintenant de graves problèmes avec le diabète et d'autres maladies chroniques. La toxicomanie et la santé mentale figurent dans la liste parce qu'elles sont les parents pauvres des maladies. Nous voulions les mettre ensemble parce qu'il y a tellement de comorbidité. Pourtant, les fournisseurs de services ont tendance à s'occuper de ces conditions séparément.

Je pense que les personnes âgées présentant des affections chroniques et complexes posent le plus de difficultés au système de soins de santé de nos jours. Il faut déterminer la façon de s'occuper des personnes lors des dix dernières années de leur vie, et concentrer nos ressources dans les soins de courte durée dans les hôpitaux n'est certainement pas la bonne solution. Bien sûr, les cyberdossiers de santé sont des outils très utiles.

I have listed these five elements. The sixth is “access,” on the next slide; it is the right service, the right place, the right time and the right people. By and large, if you look at what we are trying to do, the question is still where could it be done best, how close to home could it be done, and who can provide the services.

I have a quote, which is mine, on the next slide. However, it is basically on observation from the research I have looked at. When you look at how effective health care services are in any Western country around the world, international comparisons will show you that those who do best have a very strong primary care system. That is why the United States lags in terms of all the expenditures they have. I will share with you today some of my concerns about primary health care and primary health services in this country.

My next slide is a quote from Don Berwick: “Every system is perfectly designed to get the results it gets.” In other words, we have to go back to the design stage. The problems we have today are a result of how we design things.

Do we have patient-centred care or provider-centred care? I will leave that with you. I will not answer the question.

You can see I think we need a migration away from provider-centred care to patient-centred care.

I will venture to say that I represent only part of Ontario here today, but I have worked in three provinces and in many countries. I am originally from Montreal. I think primary care in Canada is failing. That is one of our problems. I referred to that earlier in terms of impact — how you have to have very strong primary care. I have listed some reasons on the next slide, including professional turf wars between the various disciplines and a solo practice philosophy that is prevalent even though folks work in groups.

As I alluded to before, primary care is not primary health services. We need the social services and the other supports included. This is where the polyclinic comes up in another respect: the generalist-specialist medical care interface is very weak. We need to strengthen that. Finally, there is an absence of the eHealth record. That is my 90-second rendition on primary health care.

Now I will move to the hospital sector. Most solutions to hospital problems in Canada are, in fact, outside of the hospital. Hospitals need to develop a foreign policy — policy, practices and relationships outside their four walls as well as within. The H needs to stand for “health care” more than “hospital.” I love this

J’ai énuméré cinq des directions. La sixième est l’accès, qui se trouve sur la prochaine diapositive. Il consiste en un bon service, au bon endroit, au bon moment, par les bonnes personnes. Si vous examinez ce que nous voulons faire, les questions demeurent les mêmes. Nous devons déterminer le meilleur endroit où fournir des services, voir s’ils pourraient être fournis à un endroit proche du domicile des gens et trouver des personnes qui pourraient fournir ces services.

Une de mes citations se trouve sur la prochaine diapositive. C’est essentiellement une observation qui découle des recherches que j’ai faites. Quand on voit à quel point les services de soins de santé sont efficaces dans les pays occidentaux, les comparaisons internationales indiquent que les pays qui obtiennent les meilleurs résultats sont ceux qui se sont dotés d’un solide système de soins de santé primaires. C’est pourquoi les États-Unis accusent un retard en ce qui concerne les dépenses relatives aux soins de santé. Je parlerai aujourd’hui de certaines de mes préoccupations quant aux soins de santé primaires et aux services de santé primaires au Canada.

Ma prochaine diapositive contient une citation de Don Berwick : « Chaque réseau est parfaitement conçu pour donner les résultats qu’il obtient ». Autrement dit, nous devons revenir à l’étape de la conception. Les problèmes que nous avons aujourd’hui découlent de la façon dont nous concevons les choses.

Nos soins sont-ils axés sur les patients ou les fournisseurs? Je vous laisse en juger. Je ne répondrai pas à cette question.

Comme vous pouvez le constater, je pense que nous devons passer de soins axés sur les fournisseurs à des soins axés sur les patients.

Je dirais que je représente seulement une partie de l’Ontario ici aujourd’hui, mais j’ai travaillé dans trois provinces et dans de nombreux pays. Je viens initialement de Montréal. Je crois que les soins primaires au Canada ne répondent pas aux besoins. C’est l’un de nos problèmes. J’en ai parlé plus tôt quand j’ai abordé la question de l’incidence. J’ai mentionné la nécessité d’avoir un solide système de soins de santé primaires. J’ai nommé quelques raisons pour cela sur la diapositive suivante. Ces raisons comprennent les querelles de clocher entre les professionnels des diverses disciplines et une philosophie de la pratique en solo qui est répandue, même lorsque les personnes travaillent en groupe.

Comme je l’ai mentionné auparavant, les soins primaires ne sont pas des services de santé primaires. Nous avons besoin d’inclure les services sociaux et d’autres types de soutien. C’est là que les polycliniques interviennent à nouveau. Il y a peu de contacts entre les spécialistes et les généralistes. Finalement, il y a une absence de cyberdossiers de santé. Ainsi se termine mon exposé de 90 secondes sur les soins de santé primaires.

Je parlerai maintenant du secteur hospitalier. Les solutions à la plupart des problèmes des hôpitaux au Canada se trouvent à l’extérieur des hôpitaux. Les hôpitaux doivent mettre au point une politique étrangère. Ils doivent élaborer des politiques, des pratiques et des relations à l’extérieur de leurs quatre murs ainsi

quote about how the railroads went out of business because they thought they were in the railroad business. They forgot they were in the transportation business 100 years ago.

This is what we are seeing with health maintenance organizations, HMOs, in the United States. I ask you: What percentage of hospital work could be done anywhere — in a polyclinic, for example? I suggest to you the answer is quite high: easily 50 per cent and maybe upwards of 70 per cent.

I had a good friend from Boston, which is the most over-hospital-bedded city in the world, who came to Ottawa at the turn of the century. He came to a conference on the future of the hospital in the 21st century. I asked him what he learned. He replied, "They said there would not be one." That is interesting. For the type of surgery Dr. Keon used to do, it is clear you need a hospital. However, much of the ambulatory services could be done anywhere.

When I was a medical student, had you told me dialysis and MRIs could be done in a strip mall and that heart attack patients needed to go right to the Heart Institute, I would have been dumbfounded. I would have disagreed with two of your points and I would have asked you what an MRI was. As you can see, there has been an enormous change over the years.

What does the H stand for in 2009? Is it a regional hospital that offers tertiary and other care services? Is it a district hospital? Is it a local hospital that may in fact be an urgent care centre with long-term care and not be fixated on the current hospital model?

That is where we get an opportunity for polyclinics. Again, we have to think, not only the care and the quality, but also the economics — the economies and diseconomies of scale.

On the next page, I have a slide that is hard to interpret. Renfrew County is about an hour away and with 100,000 people is the largest county in Ontario. Here we see that we can transfer 28 per cent of the ambulatory surgeries back to Renfrew. That is 3,500 surgeries a year or more than 10 surgeries a day. Moving those back, if we could, would help three or four people out there. In fact, we can.

As for planning architecture — and I think this is in tune with your polyclinic concept — one of our themes is geography. We want to bring local providers together, build solid primary health services and customize services to the needs and realities of various communities. This is very much in tune with the work you have been doing and what you are proposing.

qu'à l'intérieur. Nous devons mettre davantage l'accent sur les soins de santé que sur les hôpitaux. J'aime la citation dans laquelle on affirme que les compagnies de chemin de fer ont fait faillite parce qu'elles croyaient faire partie du secteur des chemins de fer. Elles ont oublié qu'elles faisaient partie du secteur du transport il y a 100 ans.

C'est ce que nous observons avec les organisations de soins de santé intégrés (OSSI) aux États-Unis. J'aimerais vous poser la question suivante. Quel pourcentage du travail accompli dans les hôpitaux pourrait être fait ailleurs, comme dans les polycliniques? Je vous dirais que c'est un pourcentage très élevé, à savoir entre 50 et 70 p. 100.

J'avais un bon ami de Boston, qui est la ville possédant le plus de lits d'hôpitaux au monde, qui est venu à Ottawa au début du siècle. Il est venu assister à une conférence sur l'avenir des hôpitaux au XXI^e siècle. Je lui ai demandé ce qu'il avait appris. Il m'a répondu qu'il n'y avait pas d'avenir pour les hôpitaux. J'ai trouvé sa réponse intéressante. En effet, les types d'opérations qui étaient effectuées par le Dr Keon nécessitaient un hôpital. Toutefois, la plupart des services ambulatoires pourraient être fournis ailleurs.

Lors de mes études en médecine, si quelqu'un m'avait dit que l'on pourrait effectuer une dialyse et des IRM dans un centre commercial et que les personnes ayant souffert d'une crise cardiaque devaient se rendre immédiatement à l'institut de cardiologie, j'aurais été abasourdi. J'aurais refusé d'accepter deux des points soulevés, et j'aurais demandé ce qu'était une IRM. Comme vous pouvez le constater, les choses ont changé énormément au cours des années.

Quelle signification ont les hôpitaux en 2009? Est-ce que ce sont des hôpitaux régionaux qui offrent des services tertiaires et d'autres services de soins? Est-ce un hôpital de district? Est-ce un hôpital local qui pourrait être en réalité un centre de soins d'urgence avec des soins prolongés, qui n'est pas centré sur le modèle hospitalier actuel?

C'est là qu'entrent en jeu les polycliniques. Comme je l'ai dit, nous devons penser non seulement aux soins offerts et à leur qualité, mais également aux facteurs économiques tels que les économies et les déséconomies d'échelle.

À la page suivante, j'ai une diapositive qui est difficile à interpréter. Le comté de Renfrew est à approximativement une heure de distance d'ici. Ses 100 000 habitants en font le plus grand comté de l'Ontario. Sur la diapositive, nous voyons que nous pouvons transférer 28 p. 100 des chirurgies ambulatoires à Renfrew. Cela représente 3 500 chirurgies par années ou plus de 10 opérations par jour. Si nous pouvions transférer ces chirurgies, cela permettrait d'aider trois ou quatre personnes là-bas. Ce transfert est possible.

Quant à l'architecture de planification, un de nos thèmes est la géographie. Je crois que c'est conforme au concept de polyclinique. Nous voulons regrouper les fournisseurs locaux de soins, établir des services efficaces de soins primaires et adapter les services aux besoins et aux réalités de diverses collectivités. C'est très conforme au travail que vous avez fait et à ce que vous proposez.

My next slide deals with the determinants of health. You all know downtown Ottawa. It is a tale of two cities: Dalhousie ward and the Glebe. They are separated at a diagonal by the Queensway and Bronson, and, of the 60-some odd neighbourhoods in Ottawa, the Glebe always emerges as one of the three richest and Dalhousie as one of the three poorest. Heart disease and diabetes, for example, are two- to four-fold more common in Dalhousie ward.

To me, this emphasizes the point about why we have to drill down to these communities of care and why we need to have local health interventions. This nudges us toward your polyclinic concept.

My next slide deals with communities of practice, and this is more about the medical model, which I am familiar with. How do we treat asthma in our region? How do we treat stroke in our region? How do we address the obesity problem in our region? The effort here is to guarantee a standardization of care. As I said earlier, so much can be done away from the large hospital centres. However, we need to use the virtual world we are in to see that asthma treatments are the same for a five-year-old child everywhere.

When a mom, in the winter in Barry's Bay at the edge of Algonquin Park, takes her asthmatic child in to the hospital, she may panic, and with an expensive tank of gas in an old car on winter roads drive to CHEO because she wants the best for her child. However, we know that with modern technology and clinical pathways we can provide the CHEO standards in Barry's Bay. With television hook-up we can tap into CHEO, if that child is not doing well. That gives you an idea of some of the potential.

We have looked at a number of community practices to have a standardized lab for hospitals in the Champlain area and to have a cancer surgery hub-and-spoke model. This deals with the repatriation of ambulatory surgery I was talking about earlier. We have looked to have a standardized health system and to get rehabilitation services. Rehab people already have access problems and here we bring them into the city centre. Therefore, how do we get this out to the community? We do so by providing venues like the polyclinic and by moving professionals out.

My next slide looks at maternal newborn planning. Here again, historically, we have had so much of a focus on labour and delivery that we have forgotten that we are thinking of conception on to the first year of life. Again, we are exploring how we can look at standards and provide quality care wherever a person is in this LHIN.

Ma prochaine diapositive porte sur les déterminants de la santé. Vous connaissez tous le centre-ville d'Ottawa. C'est l'histoire de deux villes, à savoir le quartier Dalhousie et le Glebe. Elles sont séparées diagonalement par le Queensway et la rue Bronson. Parmi les quelque 60 quartiers d'Ottawa, le Glebe se classe toujours parmi les trois plus riches, tandis que Dalhousie se classe parmi les trois plus pauvres. Le diabète et les maladies du cœur, par exemple, sont deux à quatre fois plus fréquentes à Dalhousie.

C'est pour cela que, à mon avis, nous devons mettre l'accent sur les communautés de soin et que nous avons besoin d'avoir des interventions de santé locales. Cela nous rapproche du concept des polycliniques.

Ma prochaine diapositive concerne les communautés de pratique. Cela porte davantage sur le modèle médical, que je connais bien. Comment traitons-nous l'asthme dans notre région? Comment traitons-nous les accidents vasculaires cérébraux dans notre région? Comment abordons-nous le problème d'obésité dans notre région? Nous nous efforçons de garantir la normalisation des soins. Comme je l'ai dit auparavant, nous pouvons faire tellement de choses à l'extérieur des grands centres hospitaliers. Toutefois, nous devons nous servir du monde virtuel dans lequel nous vivons pour voir que les traitements contre l'asthme offerts à un enfant de cinq ans sont pareils partout dans le monde.

Considérons l'exemple suivant. Une femme vivant à Barry's Bay, à la limite du parc Algonquin, doit amener son fils asthmatique à l'hôpital en plein hiver. Elle panique, et elle décide de remplir le réservoir d'essence de sa vieille voiture, ce qui lui revient cher, et de conduire sur les routes d'hiver pour se rendre au CHEO parce qu'elle veut que son enfant reçoive les meilleurs soins. Toutefois, grâce aux technologies modernes et aux cheminements cliniques, nous pouvons fournir des services de qualité similaire à Barry's Bay. Les télévisions permettent de communiquer avec le personnel du CHEO si l'enfant ne se porte pas bien. Cela vous donne une idée du potentiel de cette solution.

Nous avons examiné de nombreuses pratiques communautaires afin d'avoir un laboratoire normalisé pour les hôpitaux de la région de Champlain et d'avoir un modèle de noyau central et de rayons pour les chirurgies du cancer. Cela porte sur le rapatriement des chirurgies ambulatoires dont je parlais auparavant. Nous avons cherché à avoir un système de santé normalisé et des services de réadaptation. Le personnel de réadaptation a déjà des problèmes d'accès, et nous les amenons dans le centre-ville. Comment pouvons-nous fournir ces services aux collectivités? Nous le faisons en fournissons des sites comme les polycliniques et en déménageant les professionnels.

Ma prochaine diapositive examine la question des soins maternels et néonataux. Ici aussi, par le passé, nous nous sommes tellement concentrés sur l'accouchement que nous avons oublié de tenir compte de la période allant de la conception jusqu'à la première année de la vie. Nous examinons comment nous pouvons étudier des normes et fournir des soins de qualité quand une personne est dans le RLIS.

I will conclude with the last slide, which is a map that shows the number of hospitals we have here: 20. What can we move closer to home and, as we move into smaller hospitals, what can be worked into a polyclinic model? My answer, without quantifying it, is "a lot."

On polyclinics, we even have used the term "health villages" here, thinking of co-location. The Carleton Place hospital is looking to co-locate and they are looking to include the Children's Aid Society on the same piece of land. This is public health, Children's Aid Society, you name it.

I have provided a list of what one might do. As I said earlier, co-location is not only good for the client in terms of one-stop shopping; it fosters system building because people meet each other at the coffee urn. Even though they might be working within their silos, that interchange is healthy.

I think this is a wonderful idea that needs a Canadian flavour to it. One of the weaknesses is the interface between primary care and secondary care — the generalists-specialists interface — that the Cuban model has. However, Cuba is Cuba and Canada is Canada. Some of the models we have, the community health centres and the CLSCs, need a bit of an update in terms of where we are 25 to 40 years after their genesis.

I think there is a lot of opportunity here. I commend you for the work you have done. My favourite slide is the rowboat: we are all in this together unless we sink.

Getting back to your questions that I answered at the beginning, my answer would be let us look at this. Thank you for studying this. Let us bring it on, but let us recognize we need a Canadian flavour. For example, what we put in Orleans is an interface between the Montfort Hospital and the general practitioners in Orleans, which has a population of 100,000 people and no hospital. That is very different from what you would put in Barry's Bay.

Jodi Mucha, Director, BC Healthy Communities: It is both my pleasure and my honour to be here this afternoon to speak with you about population health and reducing the health disparities.

My aim today is to share with you the integrated model we are using in B.C. specifically to link the multiple determinants of health at the community level. This model is known as BC Healthy Communities.

First I will give you a snapshot of the initiative to provide some context for the initiative and some history. Then I will share with you with you some considerations based on the options that were presented.

BC Healthy Communities is a provincial initiative that originated out of the B.C. Ministry of Health in 2005. Our core funding was received initially by the B.C. Ministry of Health. It is

Je parlerai maintenant de ma dernière diapositive. C'est une carte qui montre le nombre d'hôpitaux que nous avons ici, à savoir 20. Quels services pouvons-nous rapprocher de chez nous et, à mesure que nous passons à des hôpitaux plus petits, que peut-on intégrer dans le modèle des polycliniques? Sans donner un nombre précis, je peux vous répondre « beaucoup de choses ».

Nous avons même utilisé le terme « villages de santé » pour parler des polycliniques en référence à la colocation. L'hôpital de Carleton Place veut procéder à une colocation, et il veut que la Société de l'aide à l'enfance se trouve sur le même terrain. Tout cela est du domaine de la santé publique, de la Société de l'aide à l'enfance, et ainsi de suite.

Je vous ai fourni une liste de ce que les personnes pourraient faire. Comme je l'ai dit auparavant, la colocation n'est pas seulement bonne pour les clients parce qu'elle fournit un guichet unique. Elle favorise aussi la construction du système parce que les gens se rencontrent devant l'urne à café. Même si ces personnes travaillent peut-être dans des domaines différents, ces échanges entre elles sont sains.

Je crois que c'est une merveilleuse idée à laquelle nous devons ajouter une saveur canadienne. L'une des faiblesses est l'interface entre les soins primaires et secondaires — les spécialistes et les généralistes — que l'on trouve dans le modèle cubain. Toutefois, le Cuba et le Canada sont deux pays différents. Certains des modèles dont nous disposons, comme les centres de santé communautaire et les CLSC, ont besoin d'une certaine mise à jour puisqu'ils ont été mis en place il y a de cela 25 à 40 ans.

Je crois qu'il y a beaucoup de possibilités ici. Je vous félicite du travail que vous avez fait. Ma diapositive préférée est le canot. Nous sommes tous dans cette situation ensemble, sauf si nous coulons.

Pour revenir aux questions auxquelles j'ai répondu au début, je dirai que nous devons examiner cette idée. Je vous remercie de l'avoir étudiée. Mettons-la en œuvre, mais reconnaissons qu'il faut lui ajouter une saveur canadienne. Par exemple, nous mettons en place à Orléans une interface entre l'Hôpital Montfort et les généralistes d'Orléans, qui a une population de 100 000 personnes et pas d'hôpital. C'est très différent de ce qu'on mettrait en place à Barry's Bay.

Jodi Mucha, directrice, BC Healthy Communities : Je suis heureuse et honorée d'être ici avec vous cet après-midi pour parler avec vous de la santé des populations et de la réduction des disparités en matière de santé.

Mon but aujourd'hui est de partager avec vous le modèle intégré que nous utilisons en Colombie-Britannique pour relier les nombreux déterminants de la santé au niveau communautaire. Ce modèle est connu sous le nom de BC Healthy Communities.

Premièrement, je vais vous donner un aperçu de l'initiative afin de fournir un certain contexte à l'initiative et une certaine histoire. Puis, je partagerai avec vous quelques facteurs à prendre en considération en fonction des options qui ont été présentées.

BC Healthy Communities est une initiative provinciale qui a été mise en place par le ministère de la Santé de la Colombie-Britannique en 2005. Notre financement de base a été reçu

now the B.C. Ministry of Healthy Living and Sport, when that new ministry was created. The overall intention is to engage governments and community organizations to link the multiple determinants of health through connecting thinking and planning, actions and programs, both interdepartmentally and intersectorally.

The initiative is based on a five-year core funding commitment by the B.C. Ministry of Healthy Living and Sport. The steward of the initiative is the Union of B.C. Municipalities. The foundation of the initiative is built on the World Health Organization's four identified success factors for healthy communities, which are political commitment, community engagement, multisectoral partnerships and healthy public policy.

We have developed an integral capacity building framework that incorporates four categories that categorize the determinants of health. Those four categories are physical and behavioural; systems and structures; cultural; and psychological and spiritual. There are some overarching actions we use to interface and work with communities to think about those alternatives. Those are learn, engage, expand assets and collaborate.

This framework guides how we engage with communities to think about and make the links between the determinants of health as well as informs thinking and planning for the future. The framework actually reflects aspects of the health goals for Canada, which include basic needs, belonging and engagement, healthy living, and a system for health.

While BC Healthy Communities is provincial in scope, we recognize there is no one-size-fits-all solution. B.C. is split into five health authority regions, and we have a regional facilitator who lives and works in each of those regions. They are responsible for working with the municipalities and communities in that region. The work is primarily focused at the local level and there may also be sub-regional clusters.

I will not go into detail on how we do this work, but we begin by offering a shared platform for a common vision and purpose through community dialogue and community capacity building. We use participatory platforms to influence and facilitate change. We carve out a space, provide opportunities to inquire about world views, and encourage reflection on action, with the focus being on people, place, and potential — the whole person in the whole community.

initialement par le ministère de la Santé de la Colombie-Britannique. Ce ministère est maintenant devenu le ministère de la Vie saine et du Sport de la Colombie-Britannique. L'intention générale est d'inciter les gouvernements et les organisations communautaires à relier les nombreux déterminants de la santé en associant la réflexion et la planification, les actions et les programmes, à la fois à l'échelle interministérielle et intersectorielle.

L'initiative est fondée sur un engagement financier de base de cinq ans pris par le ministère de la Vie saine et du Sport de la Colombie-Britannique. Le responsable de l'initiative est l'Union of B.C. Municipalities. Cette initiative est fondée sur les quatre facteurs qui, selon l'Organisation mondiale de la santé, permettent d'avoir des communautés en santé. Ces facteurs sont les suivants : un engagement politique, un engagement communautaire, des partenariats multisectoriels et une politique publique saine.

Nous avons mis en place un cadre intégral de renforcement des capacités qui intègre quatre catégories définissant les déterminants de la santé. Ces quatre catégories sont les déterminants physiques et comportementaux; les systèmes et les structures, les déterminants culturels, et les déterminants psychologiques et spirituels. Nous prenons des mesures globales pour interagir avec les collectivités et les inciter à penser à des solutions de rechange. Ce sont l'apprentissage, l'engagement, l'accroissement des atouts et la collaboration.

Ce cadre guide la façon dont nous incitons les collectivités à penser aux liens entre les déterminants de la santé et à les établir. De plus, il oriente la réflexion et la planification pour l'avenir. Ce cadre reflète en fait des aspects des objectifs en matière de santé du Canada, qui comprennent les besoins de base, l'appartenance et l'engagement, la vie saine et l'établissement d'un système de santé.

Bien que BC Healthy Communities soit une initiative de portée provinciale, nous reconnaissons qu'il n'y a pas de solution universelle. Il y a cinq régions qui sont des autorités en matière de santé en Colombie-Britannique. Il y a un facilitateur régional qui vit et qui travaille dans chacune de ces régions. Ils doivent travailler avec les municipalités et les collectivités de cette région. Le travail est surtout effectué au niveau local, et il pourrait également y avoir des groupes sous-régionaux.

Je ne donnerai pas des détails sur la façon dont cela fonctionne, mais nous offrons d'abord une plate-forme partagée pour une intention et une vision communes au moyen d'un dialogue avec la collectivité et de renforcement des capacités communautaires. Nous utilisons des plates-formes de participation pour inciter des changements et les faciliter. Nous prévoyons un espace, nous offrons des possibilités de se renseigner sur les points de vue mondiaux et nous encourageons une réflexion sur les mesures prises en mettant l'accent sur les personnes, les endroits et le potentiel, à savoir l'ensemble de la personne dans l'ensemble de la collectivité.

A key underpinning of our work is that we look not only at the determinants of health but at the determinants of health with a focus on human development. Any of you familiar with Dr. Trevor Hancock's work will know that is common to how he speaks of this type of work.

We take both individual and collective health into consideration, as well as the interior and exterior of the individual, with the emphasis placed on healthy human development, which is development that serves humans. All of our planning always looks at how this might actually serve human development — considerations such as housing, food security, economy, health and community services, et cetera.

Bringing an understanding of human development into our work allows us to understand human diversity — different views, needs, tasks, capacities, guiding principles, problems and pathologies. With this knowledge, we have a better idea of where people are coming from and what is important to them. We have more information to guide us, a better idea of where to begin and what will motivate people to join in.

With this in mind, our role is to ask, from both an individual and a collective perspective, how the determinants relate to and influence each other, and how our values, thinking and actions might impact and influence our communities. How might we support positive change that improves the overall health of our population, looking from a holistic approach at body, mind and spirit, and beyond that, at policies, the systems and supportive structures? How might we go about improving the health disparities in communities that are in many cases faced with dire situations?

Speaking to this from the community level, because all the work we do is grassroots, local-level work, I will outline a few key thoughts. Again, some of these build on comments contributed by Dr. Trevor Hancock in earlier sessions.

First and foremost, we are hearing from communities that there is a need, a readiness and a willingness to link the determinants of health. They see the opportunities. They see they can leverage more; there is more bang for the buck when they can collaborate with other organizations and work closely with municipal governments.

Part of the challenge right off the bat is that many of them do not have the capacity even to start. They are underfunded and under-resourced. Our mandate is to provide the service to go in and work with them, to take a holistic, integrated view and start thinking about some of the planning in that way.

Un des éléments clés de notre travail est que nous examinons non seulement les déterminants de la santé, mais que nous le faisons en nous concentrant sur le développement humain. Ceux qui connaissent le travail du Dr Hancock se rendront compte que c'est sa façon habituelle de parler de ce type de travail.

Nous prenons en considération la santé individuelle et collective ainsi que l'intérieur et l'extérieur de la personne. Nous mettons l'accent sur le développement humain sain, c'est-à-dire un développement au service des êtres humains. Lors de la planification, nous examinons toujours comment un facteur donné pourrait favoriser le développement humain. Ces facteurs comprennent le logement, la sécurité alimentaire, l'économie, la santé et les services communautaires.

L'apport d'une compréhension du développement humain dans notre travail nous permet de comprendre la diversité humaine, à savoir les différents points de vue, les besoins, les tâches, les capacités, les principes directeurs, les problèmes et les pathologies. Grâce à ces connaissances, nous avons une meilleure idée d'où les gens veulent en venir, et de ce qui est important pour eux. Nous avons davantage de renseignements pour nous guider, ainsi qu'une meilleure idée d'où commencer et de ce qui incitera les gens à se joindre à nous.

Avec cela à l'esprit, notre rôle consiste à demander, d'un point de vue individuel et collectif, de quelle façon les déterminants sont liés entre eux, de quelle façon ils influent les uns sur les autres et de quelle façon nos valeurs, nos pensées et nos actions pourraient avoir des répercussions sur les collectivités. Comment pouvons-nous soutenir des changements positifs qui améliorent la santé globale de notre population en examinant de manière holistique le corps, le cerveau et l'esprit et, au-delà de cela, les politiques, les systèmes et les structures de soutien? Comment pouvons-nous réduire les disparités en matière de santé dans les collectivités qui, dans bien des cas, font face à d'énormes difficultés?

En adoptant un point de vue communautaire, puisque tout notre travail est effectué au niveau local, je décrirai quelques points clés. Comme je l'ai dit, certains de ces points se fondent sur des commentaires faits par le Dr Trevor Hancock lors des sessions précédentes.

D'abord et avant tout, les collectivités nous disent qu'elles ont besoin de relier les déterminants de la santé et qu'elles sont prêtes à le faire. Elles voient les possibilités que cela offre. Elles se rendent compte qu'elles peuvent en tirer des avantages, et qu'elles en auront pour leur argent si elles collaborent avec les autres organisations et travaillent étroitement avec les administrations municipales.

L'un des problèmes, c'est qu'un grand nombre d'entre elles n'ont même pas la capacité de le faire. Elles n'ont pas assez de fonds, et elles n'ont pas assez de ressources. Notre mandat consiste à aller travailler avec elles, à adopter une approche globale et intégrée et à commencer à penser à une partie de la planification sous cet angle.

However, there are no funds or resources to support them. Essentially, they are left spinning their wheels. This is one of the challenges we are faced with as an organization. It is a provincial initiative, but what is lacking are a long-term vision and commitment and the funding and resources to support it.

There was a healthy communities initiative in B.C. in the early 1990s, but with the budget cuts in 1992 it fizzled out. In some cases, that really has more of a detrimental effect on communities. You go in and work with them and build trust, and then there is not a continued and sustained effort.

If it were possible to have a coordinated effort between the federal and provincial governments, with support to municipal government as well, using a bottom-up and top-down approach would be very effective. I know it was suggested previously, perhaps some sort of multi-sectoral committee linking population health and human development. I strongly agree that that would be a valuable structure to put in place, again acknowledging that one size does not fit all; it would be valuable to have an overarching structure to build in the flexibility, maybe some generic criteria or guidelines, but leave room for communities to address community complexity using local-level solutions.

In working with communities, we have an overall mandate to support, make links and build capacity, but that looks very different in each of the five regions, and it looks different in the various communities in those different regions.

In some cases, we have official partnerships with the health authorities, and they are responsible for delivering 21 core programs, some of which overlap. There is a focus on food security and healthy communities, so in some cases in those regions we work closely with them and have partnerships to build capacity jointly to deliver on some of those initiatives. Those are the regions in which we are very effective, and there is a lot of momentum and we are able to leverage a lot more resources and make a longer-term difference. If it were possible provincially to coordinate efforts in a fashion, I think we could get underneath each other a little more and cover all the bases, coming from top down and bottom up. Improving population health also requires focus on the settings where people live, where they work, where their children go to school and taking all of that into consideration.

Regarding measurement and evaluation that reflects human development; if there were a little more emphasis on human development within the population health model and coordinated commitment and an overarching accountability structure with

Toutefois, il n'y a pas de fonds ou de ressources pour les soutenir. Elles sont essentiellement laissées pour compte. C'est l'un des défis auxquels nous sommes confrontés en tant qu'organisation. C'est une initiative provinciale à laquelle il manque un engagement et une vision à long terme ainsi que les fonds et les ressources nécessaires pour la soutenir.

Au début des années 1990, il y avait une initiative de communautés-santé en Colombie-Britannique. Cependant, à cause des compressions budgétaires de 1992, elle est tombée à l'eau. Dans certains cas, cela a davantage des effets néfastes sur les collectivités. Nous travaillons avec eux et nous gagnons leur confiance, puis il n'y a pas d'effort continu ou soutenu.

S'il était possible d'avoir un effort concerté entre les gouvernements fédéral et provinciaux, avec un appui à l'administration municipale également, le recours à une approche ascendante et à une approche descendante serait très efficace. Je sais que cela a été suggéré auparavant. Il pourrait y avoir une sorte de comité multisectoriel qui établirait un lien entre la santé des populations et le développement humain. Je crois fermement que cela serait une structure utile à mettre en place, tout en reconnaissant de nouveau qu'il n'y a pas de solution universelle. Il serait utile d'avoir une structure globale pour permettre une certaine marge de manœuvre, peut-être des lignes directrices ou des critères génériques qui permettraient aux collectivités de résoudre leurs problèmes à l'aide de solutions locales.

Dans le cadre de notre travail avec les collectivités, nous avons un mandat global à remplir, à savoir l'établissement de liens et le renforcement des capacités, mais il semble très différent dans chacune des cinq régions et dans les diverses collectivités de ces régions différentes.

Dans certains cas, nous avons des partenariats officiels avec les autorités en matière de santé. Ces dernières sont responsables de l'exécution de 21 programmes de base, dont certains se recouperont. On met l'accent sur la sécurité alimentaire et la santé des collectivités. Par conséquent, nous travaillons étroitement avec ces régions, et nous établissons des partenariats avec elles afin de pouvoir donner suite conjointement à certaines de ces initiatives. Ce sont les régions dans lesquelles nous faisons un travail efficace. Il y a beaucoup de mouvement, et nous avons été en mesure d'obtenir un bien plus grand nombre de ressources et de changer les choses à long terme. S'il était possible de coordonner les efforts à l'échelle provinciale, cela nous aiderait à travailler un peu plus efficacement ensemble et à répondre à tous les besoins, qu'ils viennent des échelons supérieurs ou inférieurs. L'amélioration de la santé des populations exige également qu'on mette l'accent sur les endroits où les personnes vivent, où elles travaillent, où leurs enfants vont à l'école et qu'on prenne tout cela en considération.

Pour ce qui est des mesures et des évaluations du développement humain, si on mettait plus l'accent sur le développement humain dans le modèle de la santé des populations, sur la coordination des engagements et sur la mise

measurements for evaluation, there would be more of a closed loop system to continually inform and build upon. I think we need a long-term vision to sustain the efforts.

Another option outlined in the document is health impact assessments. Also, as suggested by Dr. Hancock, what about human development assessments? In some ways, this four-quadrant model we are using is somewhat of a human development assessment and a health impact assessment. We are using it with communities for them to identify what their existing assets are and where the gaps are and to identify local solutions to address the complexity in their local communities.

The other important aspect of the work we are doing is to incorporate other policy fields and have multi-sectoral groups, so as to not leave this work up to just the health practitioners and health promotion people. The criteria when we work with communities is that all the initiatives are multi-sectoral. We include planners, local government and the private sector so that everyone comes together and can start making those links and see that, from 50,000-foot view, they actually have more leveraging opportunities.

That is all I have to share with you at this moment. I am sure I will be able to shed more light on these points during the questions.

The Chair: Thank you both very much. Before turning to senators for questions, I must say that having the two of you before us is an interesting opportunity, because British Columbia is pretty much running better than anyone else in this field. Ontario got into regionalization very late, and they did not get into regionalization, or into links, so there is a tremendous opportunity for creativity there. I remember interfacing with Dr. Cushman on a number of other LHINs about a year ago on this whole subject, and we are very glad to have you here today, Dr. Cushman.

I will try to focus a little. We pretty well know what our report will say now — an all-of-government approach with strong community development. It will have vertical and horizontal integration, as you mentioned, Ms. Mucha, and try to get everyone involved in the field. The important thing is not to reinvent the wheel.

From an Ontario point of view, Dr. Cushman, there are approaches to doing the community model, including the polyclinic, but including the resources that are necessary to deal with the determinants of health. There would be no question that to expedite this in Ontario now, it would have to go through the 14 LHINs. There is no question; that is a fact of life. They are there to stay for quite some time, and that is the way it will be. We would have to build on that. Would it be enough for our

en place d'une structure de responsabilité globale contenant des mesures d'évaluation, le système serait davantage un système fermé que l'on pourrait continuellement améliorer. Je crois que nous avons besoin d'une vision à long terme pour soutenir les efforts.

Une autre option décrite dans le document est les études d'impact sur la santé. De plus, comme l'a suggéré le Dr Hancock, pourquoi ne ferions-nous pas des évaluations du développement humain? De certaines façons, ce modèle à quatre quadrants que nous utilisons est une sorte d'évaluation du développement humain et d'étude d'impact sur la santé. Nous les utilisons avec les collectivités pour qu'elles puissent déterminer quels sont leurs atouts et leurs lacunes et trouver des solutions locales pour résoudre les problèmes qu'elles ont.

L'autre aspect important du travail que nous faisons consiste à inclure d'autres secteurs politiques et d'autres groupes multisectoriels pour que ce travail ne soit pas la seule responsabilité des professionnels de la santé et du personnel responsable de la promotion de la santé. Quand nous travaillons avec les collectivités, toutes les initiatives doivent être multisectorielles. Nous incluons les planificateurs, les administrations municipales et les membres du secteur privé pour que toutes les personnes puissent se réunir, commencer à établir ces liens et se rendre compte qu'elles disposent de plus de possibilités stratégiques avec 50 000 pieds.

Ceci complète ma présentation. Je suis certain que je pourrai éclaircir certains points pendant la période des questions.

Le président : Merci beaucoup à vous deux. Avant de passer aux sénateurs pour la période des questions, je dois dire qu'il est intéressant de vous avoir ici tous les deux, car la Colombie-Britannique s'en tire beaucoup mieux que les autres provinces dans ce domaine. L'Ontario s'est tournée très tard vers la régionalisation ou le réseautage; il y a donc beaucoup de place pour la créativité. Je me souviens avoir discuté de divers autres RLIS à ce sujet avec le Dr Cushman il y a environ un an. Nous sommes d'ailleurs très heureux que vous soyez parmi nous aujourd'hui, docteur Cushman.

Je vais tenter de préciser ma pensée. Nous avons maintenant une bonne idée du contenu de votre rapport : une approche pangouvernementale misant fortement sur le développement communautaire. Comme vous l'avez indiqué, madame Mucha, elle comprendra une intégration verticale et horizontale et tentera de rallier tous les intervenants dans le domaine. Il est important de ne pas réinventer la roue.

En ce qui concerne l'Ontario, docteur Cushman, il existe des approches au modèle communautaire, dont la polyclinique, qui incluent les ressources nécessaires pour s'occuper des déterminants de la santé. Il ne fait aucun doute que pour accélérer les choses en Ontario, il faudrait passer par les 14 RLIS. C'est indubitable. Ils sont là pour rester, c'est ainsi. Nous devons partir de là. Nos recommandations devraient-elles viser les RLIS, ou devrions-nous les cibler davantage? Faudrait-il aller

recommendations to go at the LHIN level, or should there be more refinement? Should it get down to postal code and that kind of thing? Can you have sustainable community development at the level of postal code, or does it have to be something as big as an LHIN?

Dr. Cushman: That is an excellent question. I sort of straddled the line in my presentation because I mentioned Orleans, which has 100,000 people, and the polyclinic they need there is actually the sort of polyclinic that Don Beanlands described to me 10 years ago, which is a primary care secondary care interface. A hundred thousand people is really a city, even though it is part of the city of Ottawa, compared to Barry's Bay or a neighbourhood in Orleans. I referred to the difference between the Glebe and Dalhousie wards; you can walk the diagonal from one to the other. You can walk from Lansdowne Park to the river in less than an hour, and you cut across two neighbourhoods in Ottawa, one of the richest and one of the poorest.

You definitely need to drill down to the postal codes. These are true neighbourhoods. I think the City of Ottawa has identified 60 neighbourhoods it has been looking at within the city. We did the early development instrument, which looks at how prepared children are when they hit Grade 1. This was done across Ontario. We looked at the differences in the roughly 60 neighbourhoods identified by the city.

I guess a polyclinic can mean a lot of things to a lot of people. I said we have to get the local in the LHIN, because this LHIN is actually as large as six provinces in the country. That gets back to the community of care concept. I think there are different definitions of polyclinics floating around. Much is what a hospital could do, which could be closer to home, but on the other hand, the other definition, which is the one I think you are bringing from Cuba, is more like the CHC and CLSC pieces, and they both have a lot of potential.

Having services collocated in the neighbourhood, so that we can actually reconstruct the personalities and flavours of neighbourhoods, which we have lost since I was a kid, and to have these organizations co-located, would do a real service. People would know where they were, would know how to get there, and it would bring some sustainable development back into the community.

To answer your question regarding postal codes, yes, drill down to neighbourhoods, because that is when you will get primary health services that make a difference. As Ms. Mucha said, that is when you will address the true determinants of health.

The Chair: Ms. Mucha, over to you. If there is going to be an effect at making Dalhousie equal to Rockcliffe, or to the Glebe, obviously the 50 per cent of influences that determine health outcomes and well-being and productivity — and I think we have to keep addressing all three because they are intertwined — 50 per cent of those are non-health issues, right? They are social

jusqu'aux codes postaux? Est-ce qu'un développement communautaire viable fondé sur les codes postaux est possible, ou faut-il quelque chose d'aussi grand que les RLIS?

Dr Cushman : C'est une excellente question. J'ai quelque peu brouillé les cartes dans ma présentation en parlant d'Orléans, qui compte 100 000 habitants. La polyclinique dont ils ont besoin là-bas est en fait semblable à ce que Don Beanlands me décrivait il y a 10 ans, soit une interface entre les soins primaires et secondaires. Cent mille habitants, c'est en fait une ville, même si Orléans fait partie d'Ottawa, contrairement à Barry's Bay ou à un quartier d'Orléans. J'ai parlé de la différence entre les quartiers Glebe et Dalhousie. On peut marcher de l'un à l'autre. On peut marcher du parc Lansdowne à la rivière en moins d'une heure en traversant l'un des plus riches et l'un des plus pauvres des quartiers d'Ottawa.

Il faut définitivement explorer davantage l'approche fondée sur les codes postaux, car ils représentent vraiment les quartiers. Je crois que la ville d'Ottawa a ainsi identifié une soixantaine de quartiers. Nous nous sommes penchés sur le développement de la petite enfance et examiné le niveau de préparation des enfants lorsqu'ils arrivaient en première année. Nous avons fait cela partout en Ontario. Nous avons étudié les écarts dans la soixantaine de quartiers répertoriés par la ville d'Ottawa.

Je suppose qu'une polyclinique peut signifier bien des choses pour bien des gens. J'ai dit qu'il fallait que la notion de « local » fasse vraiment partie de l'expression « réseau local d'intégration des services de santé », car ce réseau est en fait aussi vaste que six des provinces du pays. Cela nous ramène au concept de la communauté de soins. Je crois qu'il existe diverses définitions de la polyclinique. L'une porte sur ce qu'un hôpital pourrait faire, soit d'être plus près des foyers, mais une autre, que vous tenez je crois de Cuba, s'apparente davantage aux CSC et aux CLSC. Les deux offrent beaucoup de possibilités.

Il serait très rentable de regrouper les services dans un même quartier afin de reconstituer les personnalités et les saveurs de ces quartiers, ce qui s'est perdu depuis ma jeunesse. Les gens sauraient où ces services sont situés et comment s'y rendre, ce qui permettrait de ramener une certaine forme de développement durable dans la communauté.

En réponse à votre question sur les codes postaux, il faudrait effectivement aller jusqu'aux quartiers, car c'est à ce niveau qu'on obtient les services de santé primaires qui font la différence. Comme Mme Mucha l'a dit, c'est à ce niveau qu'on s'attaque aux véritables déterminants de la santé.

Le président : Passons à vous, madame Mucha. Si on espère rendre le quartier Dalhousie équivalent à ceux de Rockcliffe ou de Glebe, il est évident que la moitié des déterminants de la santé, du bien-être et de la productivité — je crois qu'il faut se concentrer sur eux parce qu'ils sont interreliés — ne sont pas des questions de santé, n'est-ce pas? Il s'agit de problèmes sociaux ou de logement,

issues or housing, all of this. When you sit down to plan in British Columbia, because you are up and running, who is around the table with you?

Ms. Mucha: When we sit down to plan? Can you expand on what you are asking?

The Chair: What is your working model? You do not run everything yourself, I am sure of that. Who are your partners? Who is around the table with you?

Ms. Mucha: We have a 15-member steering committee. Eight members represent provincial organizations and seven represent communities, so we have a range. We have a representative from the Planning Institute of British Columbia, someone from British Columbia Recreation and Parks Association, four local government officials, some mayors, some councillors. There are folks from Community Futures, so that is economic development. There is 2010 Legacies Now, which is focused on Olympics, youth and literacy. It is a multi-sectoral committee. Each of those organizations has a mandate specific to capacity building, community development and sustainability. For example, we will also have a member from the British Columbia Environmental Network, so that would be environmental sustainability.

Those folks are around the table. We developed our strategic plan, and then each year we get our operational plan approved by them.

We work quite closely with some of those steering committee members on side initiatives. They are very keen on the work we are doing. In fact, one of the member organizations has hired us to develop a framework for rolling out a program in schools. We use our integrated model to bring youth into the process to determine how to increase physical activity and healthy eating in schools.

While our initiative is not focused on any one particular issue, the integrated model can be used for any issue. It can be used for specific issues, but using the integrated model ensures that all the different stakeholders are around the table and that we are taking those four different categories of the determinants of health into account in all of our planning.

We have also developed an integrated evaluation framework so that we are using that same approach to evaluate all of the work we are doing.

Senator Eggleton: Thank you for coming. I have a couple of questions. The polyclinic concept in Cuba, as I understand it, has multi-disciplinary teams. It has doctors, nurses and psychologists. It has dentists. It has all the primary health care people, but it also has social workers, speech therapists and child care services. It even does scientific research and training of people. It is quite multi-dimensional.

cette sorte de chose. Comme l'organisation existe déjà en Colombie-Britannique, qui est à la table avec vous lorsque vous vous assoyez pour planifier?

Mme Mucha : Lorsqu'on s'assoit pour planifier? Pouvez-vous préciser votre question?

Le président : Quel est votre modèle de travail? Vous ne dirigez pas tout vous-même, j'en suis sûr. Qui sont vos partenaires? Qui est à la table avec vous?

Mme Mucha : Nous avons un comité directeur composé de 15 membres. Huit d'entre eux représentent des organismes provinciaux et sept des collectivités. Il y a donc une bonne représentation. Il y a un représentant du Planning Institute of British Columbia, un de la British Columbia Recreation and Parks Association, quatre représentants gouvernementaux locaux, des maires, des conseillers. Il y a des représentants d'Aide au développement des collectivités, ce qui couvre la portion développement économique. 2010 Legacies Now, qui se concentre sur la Olympiques, la jeunesse et l'alphabétisation, est également représenté. Il s'agit d'un comité multisectoriel. Chacun des organismes participants dispose d'un mandat précis en matière de développement des capacités, de développement communautaire et de durabilité. Nous aurons bientôt une nouvelle facette en matière de durabilité environnementale en la présence d'un nouveau membre du British Columbia Environmental Network.

Tous ces gens sont à la table. Nous avons élaboré notre plan stratégique, et ils approuvent chaque année notre plan opérationnel.

Nous travaillons en étroite collaboration avec certains membres de ce comité directeur au sujet d'initiatives parallèles. Notre travail les intéresse beaucoup. Un des organismes membres a d'ailleurs retenu nos services pour élaborer le cadre de mise en œuvre d'un programme dans les écoles. Nous utilisons notre modèle intégré pour amener les jeunes à participer au processus afin de déterminer comment promouvoir l'activité physique et les saines habitudes alimentaires dans les écoles.

Comme notre initiative n'est pas ciblée, le modèle intégré peut donc être utilisé dans n'importe quelle situation. Il peut servir pour régler des questions bien précises, mais son utilisation permet de s'assurer que tous les intervenants sont à la table et que nous tenons compte de ces quatre catégories de déterminants de la santé dans l'ensemble de la planification.

Nous avons aussi élaboré un cadre d'évaluation intégré; nous utilisons donc cette même approche pour évaluer tout ce que nous faisons.

Le sénateur Eggleton : Merci d'être ici. J'ai quelques questions. Tel que je le comprends, le concept de la polyclinique à Cuba englobe des équipes pluridisciplinaires. Il y a des médecins, des infirmières, des psychologues, des dentistes. Il comprend non seulement toutes les personnes chargées d'offrir des soins de santé primaires, mais aussi des travailleurs sociaux, des orthophonistes et des puéricultrices. On y fait même de la recherche scientifique et de la formation de personnel. C'est très varié.

Is there anything like that here in Canada? Is there such a facility here in Canada at this point?

Dr. Cushman: I think there are models — the CLSCs and the community health centres, for example — but what is there is very much a patchwork quilt, and not comprehensive. There is wide variation. Some may share a speech pathologist; some may not have one.

This is what I was alluding to before: the primary care is not primary health services. We need to go well beyond that. Even an organization like Meals on Wheels, for example, could be done out of these neighbourhood clinics.

The short answer is we have little that truly compares, but certainly, in terms of our sense of how we need to build better primary health services, there is much that could be done.

Senator Eggleton: Ms. Mucha, I take it that much of what you do is to bring about a coordination of different agencies that are involved in social services and things other than primary health, as opposed to trying to integrate all these services in one location, one-stop shopping; is that correct?

Ms. Mucha: Yes. We are more or less the organization that is at that 50,000-foot view. When working with communities we make sure they are incorporating or including people from the different agencies, that there are multi-sectoral committees and stakeholder groups. We do play more of that coordination role.

Senator Eggleton: Do you have one facility that has all the different services in it and deals with the social determinants of health in the broadest context?

Ms. Mucha: Yes and no. We work closely with the other organizations across the province that deliver on those different services. In many cases we have developed partnerships with those organizations, or we will develop joint initiatives with those organizations. However, we are pointing to and trying to link as much as possible to those other organizations to bring them into the planning process. We are trying to build provincial capacity overall and partnerships with those organizations out there. One example is the BC Healthy Living Alliance, which works specifically to increase physical activity, healthy eating and tobacco reduction. They have a capacity building strategy that provides capacity support for each of those three items. I said earlier that we have a regional facilitator who works in each of the regions. They were going to hire a facilitator for each of the regions. The northern region is the size of France. It is a very large region for one person. Because there was such an overlap and complementary mandates, we developed a partnership with them to hire two jointly shared positions, one of ours and one of theirs. They are using our integrated approach specific to the capacity that they are building for those three things: healthy eating, physical activity and tobacco reduction.

We are not all these people working out in the regions tripping over each other. We are also building communities of practice, so those professionals and practitioners working out in the field are

Existe-t-il en ce moment quelque chose de semblable au Canada?

Dr Cushman : Je crois qu'il existe des modèles, les CLSC et les centres de santé communautaire par exemple, mais ce qui existe est plutôt disparate et non intégré. Il y a beaucoup de variations. Certains établissements peuvent par exemple se partager un orthophoniste, alors que d'autres n'en ont tout simplement pas.

C'est ce que je disais plus tôt. Les soins primaires ne sont pas des services de santé primaires. Il faut aller plus loin. Même des services comme la popote roulante pourraient être offerts à partir de ces cliniques de quartier.

Bref, nous avons peu de véritables points de comparaison, mais nous avons certainement beaucoup à faire pour en arriver à de meilleurs services de santé primaires.

Le sénateur Eggleton : Madame Mucha, je crois que votre travail vise surtout la coordination de divers organismes de services sociaux et autres non liés aux soins de santé primaires, plutôt que l'intégration de tous ces services en un seul et même endroit. Est-ce exact?

Mme Mucha : Oui. Nous sommes plus ou moins l'organisme qui a une vue d'ensemble à très haute altitude. Lorsque nous travaillons avec les collectivités, nous faisons en sorte qu'elles incorporent ou incluent des représentants des divers organismes, qu'elles forment des comités et des groupes d'intervenants multisectoriels. Nous jouons davantage un rôle de coordination.

Le sénateur Eggleton : Avez-vous une installation regroupant tous les différents services et qui s'occupe de façon générale des déterminants sociaux de la santé?

Mme Mucha : Oui et non. Nous travaillons en étroite collaboration avec les autres organismes de la province qui offrent ces différents services. Dans bien des cas, soit nous avons développé des partenariats avec ces organismes, soit nous allons le faire. Nous nous efforçons toutefois de communiquer avec ces organismes afin qu'ils participent au processus de planification. Nous tentons de constituer une capacité provinciale globale ainsi que des partenariats avec ces organismes. Je pense par exemple à la BC Healthy Living Alliance, dont le but est de promouvoir l'activité physique, les saines habitudes alimentaires et la réduction de l'usage de produits du tabac. Cet organisme possède une stratégie de développement des capacités pour chacun de ces objectifs. Ses dirigeants comptaient embaucher un facilitateur pour chacune des régions. La région la plus au nord est aussi grande que la France. Cela fait beaucoup pour une seule personne. En raison du chevauchement et des mandats complémentaires, nous avons élaboré un partenariat avec cet organisme afin d'embaucher conjointement deux personnes. L'organisme utilise notre approche intégrée pour développer les capacités liées à ses trois objectifs, soit l'activité physique, les saines habitudes alimentaires et la réduction de l'usage de produits du tabac.

Nous ne sommes pas de ces gens qui travaillent dans les régions en se marchant sur les pieds. Nous constituons également des communautés de praticiens afin de regrouper les professionnels et

actually coming together. They are learning together, sharing together, building together, and they are also able to sharpen their skills and work closely together in that way.

Dr. Cushman: If I might add, from your Toronto experience, Senator Eggleton, you would probably have as good a sense as anyone about what could be under one roof. Certainly, from my work with the City of Ottawa I learned more about the interrelation of services, including the social services, than I did from my time spent in an emergency room.

We need to know how much health and social services we can put into one neighbourhood. As well, interesting links need to be considered, and whether they should be embedded close to the schools, for example. We have so many different departments and so many different governments. At the neighbourhood level, there is great potential to co-locate many of these services that need to be at the local level.

Senator Eggleton: I appreciate your answer. I will explore one more question.

In your slide on health villages, which is our polyclinic concept for Canada, you have included a number of things, which you also referenced. What makes sense to co-locate? You would have to look at each situation, because one size does not fit all. What might be appropriate in Toronto would not be appropriate in Northern Ontario, perhaps.

How do you envision this? How far can we go? The biggest social determinant of health is poverty. How would you address that in terms of a clinic? Would you have social workers and welfare workers? "Social determinants" is a pretty broad category. You could end up with a great deal under one roof.

Dr. Cushman: It is very broad. Health services have so little direct impact. The Somerset West Community Health Centre is about two or three kilometres from Parliament Hill. It has services with nurse practitioners and physicians and many social services. There is much effort to empower people, with everything from community gardens to the Quebec model of the eggs, milk and oranges, for example, which came out of the Montreal Diet Dispensary. These are food supplements for pregnant women. Again, to deliver that, you have to be in the neighbourhood, almost at the curbside.

To your point, one size does not fit all, but if we are to address the social determinants of health, drilling down to the neighbourhood level is primary. The whole empowerment piece is very important too. For example, in Ottawa, the public health department is using youth facilitators to go into the schools because they figure the kids would rather hear from kids a few years older than from someone their parents' age.

There are all kinds of things you can do. A key issue at the local level is having the resources on hand and good solid communication among all the players so that you can manage and address the top one or two problems in a given neighbourhood, which Ms. Mucha alluded to. It is important to have things like

les intervenants spécialisés sur le terrain. Ils apprennent, partagent et construisent ensemble, et ils peuvent ainsi affiner leurs compétences et travailler en plus étroite collaboration.

Dr Cushman : Si je puis me permettre, d'après votre expérience à Toronto, sénateur Eggleton, vous savez probablement autant que quiconque quels services pourraient se retrouver sous un même toit. Pour ma part, mon travail à la ville d'Ottawa m'a permis d'en apprendre davantage sur l'interrelation des services, y compris des services sociaux, que le temps que j'ai pu passer dans une salle d'urgence.

Nous devons savoir quelle quantité de services sociaux et de santé il est possible d'implanter dans un quartier. Il faut aussi songer aux liens prometteurs et déterminer s'il faudrait les intégrer près des écoles, par exemple. Il y a tellement de ministères et d'ordres de gouvernement. À l'échelle d'un quartier, il est certainement possible de regrouper bon nombre de ces services qui devraient être locaux.

Le sénateur Eggleton : Je vous remercie pour votre réponse. J'ai une autre question.

Dans votre diapositive sur les villages de santé, qui est votre concept de la polyclinique pour le Canada, vous avez inclus divers éléments. Quels services serait-il logique, selon vous, de regrouper? Il faudrait étudier chaque situation, car il ne peut y avoir de solution unique. Ce qui convient à Toronto ne convient peut-être pas au Nord de l'Ontario.

Comment envisagez-vous cela? Jusqu'où pouvons-nous aller? Le principal déterminant social de la santé est la pauvreté. Comment s'y attaquer avec une clinique? Est-ce qu'il y aurait des travailleurs sociaux? « Déterminants social » est assez vaste. Bien des intervenants pourraient se retrouver sous un même toit.

Dr Cushman : C'est très vaste. Les services de santé ont une incidence directe tellement minime. Le Centre de santé communautaire Somerset Ouest est à deux ou trois kilomètres de la Colline du Parlement. On y retrouve des infirmières praticiennes, des médecins et de nombreux services sociaux. On s'efforce de donner les moyens aux gens, qu'il s'agisse de jardins communautaires ou de programmes comme le modèle québécois des œufs, du lait et des oranges, qui vient du Dispensaire diététique de Montréal. Il s'agit de suppléments alimentaires pour les femmes enceintes. Pour mettre en œuvre ce programme, il faut être présent dans le quartier, pratiquement sur le coin de la rue.

Pour répondre à votre question, il n'y a pas de solution unique à toutes les situations, mais si nous devons nous attaquer aux déterminants sociaux de la santé, il est essentiel de le faire à partir des quartiers. L'habilitation est également très importante. À Ottawa par exemple, le service de santé publique envoie de jeunes facilitateurs dans les écoles selon le raisonnement que les jeunes préfèrent entendre d'autres jeunes un peu plus vieux qu'eux plutôt que des adultes ayant l'âge de leurs parents.

Les possibilités sont nombreuses. À l'échelle locale, il est essentiel que les ressources soient à portée de la main et qu'il y ait une bonne communication entre tous les intervenants afin de pouvoir gérer et attaquer efficacement le principal problème dans un quartier, comme Mme Mucha l'a mentionné. Il est important

job training on site at the local level. The Cuban model is wonderful. As you said, senator, poverty is the number one social determinant of health. It is hard to find a country poorer than Cuba, so they have really addressed the issue. When we think about poverty, health care and determinants of health, we tend to be a little existential. Cuba has put poverty on its heels in terms of health status, so they must be doing something right. We need to learn from them.

Senator Eaton: Dr. Cushman, I loved your presentation. I started off my volunteer life at the age of 16 by working in the Montreal Diet Dispensary taking down ladies' bios before they were admitted.

I certainly agree with Senator Eggleton's comments. If you had your way and we put polyclinics in place at the grassroots level, what role would you see for the federal government? Would it be responsible for setting uniform health standards across Canada? Would we have accountability?

Dr. Cushman: That is a tough question, senator. I have worked for the City of Ottawa. In terms of population, Ottawa is fifth or sixth in the country. When the surrounding cities amalgamated with Ottawa, we lost that neighbourhood flavour. There were good reasons for amalgamation, such as public transit and infrastructure. However, at the true community level, we have a problem. We need three levels of government in this country: the first is neighbourhood; the second is regional; and the third is federal. Some things are best decided in your backyard; some things are best decided as a region; and other things are best taken care of at the federal level. If the federal government is to invest in this, it wants a return on that investment.

Senator Eaton: It is not so much a return, but if we believe that the neighbourhood is the best model, then do we not want the same standards of health for people living in B.C. as we want for those living in New Brunswick?

Dr. Cushman: Right, and we have that problem with respect to heart surgery. Rest assured that in terms of dietary supplements in pregnancy, it will be even more difficult. We need to make a series of interventions available, almost like a menu, from which you would choose according to the drivers in your community. I would hope that these would all be based on best practices so that you would know the cost-effectiveness equations and the evaluation formulas. The accountability piece would be worked out.

Senator Eaton: Yes.

Ms. Mucha, we have pilot programs with best practices but we do not seem to share them. When you sit at 50,000 feet and look down at all the communities, your steering committee helps. Do you see pilot programs being used or developed in communities that could apply to other communities?

de pouvoir offrir de la formation sur place. Le modèle cubain est merveilleux. Comme vous l'avez dit, sénateur, la pauvreté est le principal déterminant social de la santé. Peu de pays sont plus pauvres que Cuba, et on s'est vraiment attaqué à ce problème là-bas. Quand nous pensons à la pauvreté, aux soins de santé et aux déterminants de la santé, nous avons tendance à être quelque peu existentiels. Cuba a relégué aux oubliettes la pauvreté en tant que déterminant de la santé. Nous devons en tirer des leçons.

Le sénateur Eaton : J'ai adoré votre présentation, docteur Cushman. Ma carrière de bénévole a débuté à l'âge de 16 ans à prendre en note les coordonnées des femmes avant leur admission au Dispensaire diététique de Montréal.

Je suis certainement d'accord avec les observations du sénateur Eggleton. Si on vous donnait carte blanche et qu'il y avait des polycliniques communautaires, quel rôle selon vous devrait jouer le gouvernement fédéral? Devrait-il établir des règles uniformes en matière de santé partout au Canada? Y aurait-il reddition de comptes?

Dr Cushman : Voilà une question difficile, sénateur. J'ai travaillé pour la ville d'Ottawa. Sa population en fait la cinquième ou sixième ville en importance au pays. Nous avons perdu cette notion de quartier lorsque les villes avoisinantes ont été fusionnées à Ottawa. Il y avait des motifs valables derrière cette fusion, comme le transport en commun et l'infrastructure. Cela pose toutefois un problème à l'échelle de la communauté. Il nous faut trois ordres de gouvernement dans ce pays. Le premier est à l'échelle du quartier, le deuxième à l'échelle régionale, et le troisième à l'échelle fédérale. Certaines décisions sont mieux prises dans votre arrière-cour. Il vaut mieux prendre certaines autres dans une optique régionale, alors que d'autres sont de compétence fédérale. Si le gouvernement fédéral doit investir dans cette entreprise, il voudra des résultats.

Le sénateur Eaton : Ce n'est pas tant une question de résultats. Mais si nous croyons que le quartier constitue le meilleur modèle, ne serait-il pas logique de vouloir appliquer les mêmes normes de santé en Colombie-Britannique et au Nouveau-Brunswick?

Dr Cushman : En effet. Nous avons ce problème au sujet de la chirurgie cardiaque. Vous pouvez être certain que la situation sera encore plus difficile en ce qui concerne les suppléments alimentaires pendant la grossesse. Il faudrait que l'on puisse offrir une série d'interventions, un peu comme dans un menu, parmi lesquelles on choisirait celles qui conviennent en fonction des moteurs de la collectivité. J'espère qu'elles seraient fondées sur les meilleures pratiques; on connaîtrait ainsi les équations de rentabilité et les formules d'évaluation. La reddition de compte serait réglée.

Le sénateur Eaton : Oui.

Madame Mucha, nous avons des programmes pilotes comprenant les meilleures pratiques, mais nous ne semblons pas les partager. Avec tout ce recul que vous avez au sujet des collectivités, le comité directeur est utile. Savez-vous si des programmes pilotes utilisés ou élaborés dans certaines collectivités pourraient être mis en œuvre dans d'autres?

Ms. Mucha: Absolutely, but we would not necessarily call them pilot projects. These communities are in their readiness and willingness emerging as leaders. We see what they do with our process and the results. We can then take that information and use it as a mechanism for informing and sharing with other communities to help them learn how to proceed. In some cases, we might even link them directly so that they develop relationships with sister communities to learn from each other.

I am not sure a community would like to be called a pilot project community. Many of the communities we work with are smaller, and many of them have been researched to death. There is a level of cynicism toward being a research specimen. Again, we see what emerges as they use this process, and we then use that as an opportunity to share our learning.

Senator Eaton: You share their experience.

Ms. Mucha: Yes. As I said earlier about the quadrant model, we interact constantly to learn, engage, expand assets and collaborate. There is a constant feedback loop in the learning. We simply facilitate the process. We are not going to teach them anything. We are learning with them and guiding a process of asking questions and providing a map, if you will, for them to start seeing the links between the determinants.

Senator Pèpin: Do you mind if I switch to French?

[Translation]

If I have understood correctly, Ms. Mucha, you have five regions, several partners and five groups around a table. Obviously, that is very good for community work. How are the working relations of the groups and the regions? Are their mandates complementary? You say that you are in a learning phase and that there is overlap. How is it working in general?

[English]

Ms. Mucha: When our initiative began, we travelled around the province and introduced ourselves. We started by looking at where other healthy community initiatives were. We went to them to find out what they were doing and how we might build from that. We are linked to the Union of British Columbia Municipalities and therefore municipalities know about us. How we work is that communities approach us. We do not go to them. We tell them this is our program; you should use it; this is how it should look. We are selling a process, an integrated and holistic way of thinking, which links those determinants of health.

The communities we are working have a level of readiness. They approach us and ask us how we can do business in a different way. Is not the definition of insanity doing the same thing over and over and expecting a different result? The model

Mme Mucha : Absolument, mais nous ne les appelons pas nécessairement des projets pilotes. L'état de préparation et la volonté dont font preuve ces collectivités en font des chefs de file. Nous voyons les résultats qu'elles obtiennent avec notre processus. Nous pouvons alors prendre cette information et l'utiliser pour la partager avec d'autres collectivités qui pourront à leur tour apprendre comment procéder. Dans certains cas, nous créons même des liens directs afin que des collectivités semblables puissent nouer des liens et apprendre l'une de l'autre.

Je ne sais pas si une collectivité aimerait être perçue comme un projet pilote. Bien des collectivités avec lesquelles nous travaillons sont petites et ont déjà fait l'objet de trop d'études. Elles ont développé un certain cynisme à cet égard. Encore une fois, nous observons ce qui ressort de l'utilisation de ce processus, puis nous partageons les résultats de cet apprentissage.

Le sénateur Eaton : Vous partagez leur expérience.

Mme Mucha : En effet. Comme je l'ai dit plus tôt au sujet du modèle du quadrant, nous investissons constamment dans l'apprentissage, l'engagement, l'expansion des acquis et la collaboration. Le processus d'apprentissage comprend une boucle de rétroaction constante. Nous ne faisons que faciliter le processus. Nous ne leur apprenons rien. Nous apprenons avec eux et guidons un processus de questionnements. Nous fournissons en quelque sorte une carte routière qui leur permet de commencer à déceler les liens entre les déterminants.

Le sénateur Pèpin : Est-ce que cela vous dérange si je passe au français?

[Français]

Si je comprends bien, madame Mucha, vous avez cinq régions, plusieurs partenaires et cinq groupes autour d'une table. Évidemment, pour un travail communautaire, c'est très bien. Comment sont les relations de travail entre les groupes et les régions? Les mandats sont-ils complémentaires? Vous dites que vous êtes à une étape d'apprentissage et qu'il existe des chevauchements. Comment cela fonctionne, dans l'ensemble?

[Traduction]

Mme Mucha : Lorsque nous avons mis notre initiative en œuvre, nous avons parcouru la province pour nous présenter. Nous avons d'abord cherché où il y avait des initiatives de collectivités en santé. Nous avons demandé aux responsables ce qu'ils avaient fait et comment nous pourrions nous en inspirer. Nous avons des liens avec l'Union des municipalités de la Colombie-Britannique; les municipalités de la province connaissent donc notre existence. Nous n'approchons pas les collectivités. Ce sont elles qui viennent à nous. Nous leur présentons notre programme et nous leur disons comment elles devraient l'utiliser et quels résultats elles devraient obtenir. Nous vendons un processus, une façon intégrée et globale de penser qui relie entre eux les déterminants de la santé.

Les collectivités avec lesquelles nous collaborons ont atteint un certain niveau de préparation. Elles nous approchent et nous demandent comment procéder autrement. La définition de la folie n'est-elle pas de refaire sans cesse les choses de la même façon tout

we are using allows them to start to go beneath the complexity of the issues in their community and see them from another perspective, see that there is another way of doing business.

We may work in specific communities or sub-regions. I have not yet experienced any strong difficulties or distance between communities in the regions. They are happy to be learning. There is a strong sense of solidarity in those regions.

There are differences between the regions themselves, such as the northern region and the Vancouver Island region. Part of it is a perception that we in Victoria are making decisions — just like those in Ottawa are making decisions — for local communities. That is part of our conversations and raising awareness to allow them to start to see their world views and how those can get in the way.

[Translation]

Senator Pépin: Do you have a group that looks after seniors? We hear more and more about seniors' problems. Do you have a group that is examining this issue in particular?

[English]

Ms. Mucha: We do not have a specific group for anyone. It is all integrated. We are asked to sit at the table and hold seats on committees that may have a specific focus on seniors or youth. However, I think the interest of people to have us present at the table is to bring this integrated perspective. For example, in an initiative we are working on now with a steering committee member who hired us, we recommended that the committee should be 50 per cent youth and 50 per cent adults. It is very successful. We are rolling out the initiative.

[Translation]

Senator Pépin: Doctors and nurses work in your polyclinics. We talked about Cuban clinics. They have dentists, psychologists, psychiatrists, dentists, speech-language pathologists and psychotherapists. Do you provide or do you hope to provide these services? Is there a way to integrate them?

Dr. Cushman: The possibilities are vast. There could be dentists, child protection and welfare services, unemployment services and many others. The challenge is to determine what kind of polyclinic you want to have. We are focussing first on basic services and there are some problems that persist. Not all services necessarily need to be provided solely in hospitals. There are a great number of possibilities for establishing polyclinics, for example, in Orléans. It is a question of definition.

Dr. Beanlands, Dr. Keon's former colleague, explained to me that with the polyclinic concept there is extensive collaboration between general practitioners and specialists and this reduces wait times for patients. The model we are describing today resembles a

en s'attendant à des résultats différents? Le modèle que nous utilisons leur permet de voir sous un angle nouveau la complexité des problèmes qui les accablent afin de constater qu'il est possible de faire les choses autrement.

Nous pouvons travailler dans des collectivités ou des sous-régions précises. Je n'ai pas encore rencontré de difficultés majeures auprès des collectivités des régions. Elles sont heureuses d'apprendre. Le sentiment de solidarité est fort dans ces régions.

Il existe des différences d'une région à l'autre, comme dans le Nord et dans l'île de Vancouver. Cela réside en partie dans le fait que les gens ont l'impression que c'est à Victoria qu'on prend les décisions pour les collectivités locales, un peu comme c'est le cas ici à Ottawa. Cela fait partie de la façon dont nous les amenons à constater comment leur vision du monde peut leur nuire.

[Français]

Le sénateur Pépin : Avez-vous un groupe qui s'occupe des personnes âgées. On entend de plus en plus parler des problèmes liés aux personnes âgées. Avez-vous un groupe qui se penche sur cette question de façon spécifique?

[Traduction]

Mme Mucha : Nous n'avons de groupe particulier pour quiconque. Tout est intégré. On nous demande de nous asseoir à la table et de faire partie de comités qui peuvent se pencher sur les aînés ou les jeunes. Je crois toutefois que les gens veulent que nous soyons présents pour cette perspective d'intégration que nous apportons. Par exemple, dans le cadre d'une initiative à laquelle nous participons actuellement avec un membre du comité directeur qui a retenu nos services, nous avons recommandé que le comité soit composé à parts égales de jeunes et d'adultes. Cette idée a eu un franc succès et nous la mettons en œuvre.

[Français]

Le sénateur Pépin : Docteur Cushman, dans vos polycliniques il y a des médecins et des infirmières. On a parlé des cliniques cubaines. Elles ont des dentistes, des psychologues, des psychiatres, des dentistes, des orthophonistes et des psychothérapeutes. Offrez-vous ces services ou souhaitez-vous les offrir? Y aurait-il une façon de les intégrer?

Dr Cushman : Les possibilités sont énormes. Il pourrait y avoir des dentistes, des agences de protection de la jeunesse et d'aide à l'enfance, des services offerts aux chômeurs et plusieurs autres. Le défi est de déterminer le type de polyclinique que l'on désire. Nous misons d'abord sur les services de base et certains problèmes demeurent. Il n'est pas nécessaire que tous les services soient offerts uniquement dans les hôpitaux. De grandes possibilités existent pour créer des polycliniques, par exemple, à Orléans. C'est une question de définition.

Le Dr Beanlands, ex-collègue du Dr Keon, m'a expliqué la notion de polyclinique où il existe une grande collaboration entre les omnipraticiens et les spécialistes afin de réduire les temps d'attente pour les patients. Le modèle que l'on décrit aujourd'hui

CLSC or CHC, where we focus on neighbourhood services. A particular neighbourhood may need a doctor rather than a specialist.

Senator Pépin: Or nurses.

Dr. Cushman: You can add a whole host of services. The important thing at each location is to emphasize cooperation by focusing on the needs of the neighbourhood. That is the underlying principle of primary care, not just in health but also in social services and all that it entails.

Senator Pépin: Does that include nurses?

Dr. Cushman: Absolutely.

[English]

Senator Callbeck: Thank you for appearing today. Ms. Mucha, I am interested in the B.C. model. How many years have you had the health authorities?

Ms. Mucha: The health authority is a separate initiative. I believe it started early in 2000. I am not sure exactly.

Senator Callbeck: How do BC Healthy Communities and the health authorities work together? Do the health authorities elect people on the board?

Ms. Mucha: To be honest, I am not sure.

Senator Callbeck: They would have an appointed or elected board that develops a plan for how they will fight poverty in that area. You are a completely separate group with 15 members on your committee; you are in Victoria, and you are making decisions. You said there is a facilitator. From your budget, do you pay for the facilitator in each of those regions?

Ms. Mucha: Correct. We have a facilitator who lives and works in each of those regions. It is completely up to us whether we interface with the health authority. There is no mandated structure for us to plan or interface with them because we are out there working at the local community level. It depends on how the health authority is set up in each region to deliver its core services. In as many cases as possible, we work with those who are working out in the communities and with some who may be based in the research departments.

The effort to integrate the planning between the health authority and our initiative is up to us in each of the regions. It is not a provincial activity necessarily. It is developing a relationship with the health authority in the region. We have a partnership with Northern Health in the North. They provide funding to support the facilitator that we have in that region because of the work that they would be doing out in the field anyway. With some of the other health authorities, however, it is more about lines of communication and sharing. We are not working as closely together.

Senator Callbeck: Anyway, it works.

ressemble à celui des CLSC ou des CHC où on mise sur les services de quartier. Un quartier en particulier n'a peut-être pas besoin d'un spécialiste mais d'avantage d'un médecin.

Le sénateur Pépin : Ou d'infirmières.

Dr Cushman : Vous pouvez ajouter tout un menu de services. L'important est de mettre l'accent, dans chaque site, sur la collaboration et en misant sur les besoins du quartier. C'est le principe fondamental des soins primaires non seulement en santé mais aussi en services sociaux et tout ce que cela implique.

Le sénateur Pépin : Cela comprend les infirmières?

Dr Cushman : Sans aucun doute.

[Traduction]

Le sénateur Callbeck : Merci d'être ici aujourd'hui. Madame Mucha, le modèle de la Colombie-Britannique m'intéresse. Depuis combien de temps êtes-vous en charge des autorités en matière de santé?

Mme Mucha : Les autorités en matière de santé sont une initiative distincte. Je crois que cela a commencé en 2000. Je n'en suis pas sûre.

Le sénateur Callbeck : Quels sont les liens entre BC Healthy Communities et les autorités en matière de santé? Est-ce que ces autorités nomment les membres du comité?

Mme Mucha : Pour être franche, je ne sais pas vraiment.

Le sénateur Callbeck : Ces autorités doivent avoir un conseil nommé ou élu qui élabore un plan de lutte à la pauvreté dans une région. Vous formez un groupe totalement indépendant et votre comité est constitué de 15 membres. Vous êtes à Victoria et vous prenez les décisions. Vous avez parlé de facilitateurs. En vous fondant sur votre budget, est-ce que vous versez le salaire du facilitateur dans chacune des régions?

Mme Mucha : Oui. Nous avons un facilitateur qui vit et travaille dans chacune de ces régions. C'est entièrement à nous que revient la décision d'interagir avec les autorités en matière de santé. Aucun mandat ne nous oblige à interagir avec elles parce qu'on nous sommes sur le terrain, dans la communauté. Cela dépend de leur capacité à offrir des services de base dans les régions. Dans la mesure du possible, nous travaillons avec les intervenants qui œuvrent dans les collectivités et avec des chercheurs.

C'est à nous qu'il revient de s'efforcer d'intégrer nos plans et ceux des autorités en matière de santé dans chacune des régions. Cela ne relève pas nécessairement de la province. Il s'agit de nouer des liens avec les autorités régionales en matière de santé. Dans le Nord, nous avons un partenariat avec Service de santé du Nord, qui assure le soutien financier de notre facilitateur dans cette région en raison du travail que cet organisme devrait faire de toute façon sur le terrain. Dans d'autres régions toutefois, il s'agit davantage de communication et de partage d'information. Nous ne travaillons pas en aussi étroite collaboration.

Le sénateur Callbeck : De toute façon, ça fonctionne.

Ms. Mucha: It has been working, but there are more opportunities to work together. The initiative began in late fall 2005, so it has taken some time to figure out what it looks like. We did not develop programs to deliver. It is more a process to find out what communities need and how can we support them. Now that we have been out there for a few years, we have been able to use some examples. Senator Eaton asked earlier about the pilot communities. We can actually see how we use this process in this case. What we have learned from this, we can now present as an opportunity to work with other people. In some cases, we are doing that with the health authorities.

Senator Callbeck: That is good.

Dr. Cushman, I have one question. What would you say is the minimum number of people for an area for a polyclinic and what is the maximum?

Dr. Cushman: That is a good question. If you use the traditional medical definition, it would be quite a bit bigger. This is what we are looking at in Orleans, which is an interface of about 20 family physicians, many specialists, an MRI and mental health and addiction services, mammography, and so on. It could be a mini hospital. That is one side. The other side is what we have been talking about today: what you need in your neighbourhood. To be at the neighbourhood level, I think you will see that the health care piece diminishes while you increase the other pieces, which are more the social services and the community development piece.

You need some primary medical care, but, further down the line, there are advantages to coupling the primary medical care with specialty care. The Somerset West Community Health Centre, for example, has visiting specialists. They may have four days in a week where they have visiting specialists of different kinds, such as psychiatry or paediatrics. Much of what they are doing there is based on the social services, addressing community gardens, and job training.

To ground this the way the Cubans have done it and the way I understand you folks are thinking of it, this would be in the neighbourhood. You might have a centre of health care people, but it must be broader in terms of the social services and the community development piece, which is what Ms. Mucha alluded to.

That is a long answer to tell you that I do not really know and it depends.

The Chair: Building on that, whether they are large or small, for example, the Orleans model, one of the things they lack — and having been there to look at it I am familiar with it — is an integration with public health and social services, which I think could occur at that level also. The Montfort Hospital unloads the sophisticated health care delivery stuff, so to speak.

Do you see a possibility of getting some of those social determinants of health integrated into the Orleans clinic?

Mme Mucha: Oui, mais il y a d'autres occasions de collaboration. Notre initiative a débuté à la fin de l'automne 2005; il a donc fallu un certain temps pour déterminer le pourquoi et le comment. Nous n'avons pas élaboré des programmes destinés à produire des résultats. Il s'agit plutôt d'un processus destiné à déterminer les besoins des collectivités et comment nous pouvons leur venir en aide. Après quelques années d'existence, nous sommes maintenant en mesure de présenter des exemples. Plus tôt, le sénateur Eaton a posé une question au sujet de collectivités pilotes. Nous pouvons voir comment utiliser ce processus dans un tel cas. Nous pouvons maintenant nous en servir pour travailler avec d'autres. C'est ce que nous faisons dans certains cas avec les autorités en matière de santé.

Le sénateur Callbeck : C'est bien.

Docteur Cushman, j'ai une question pour vous. Selon vous, quel est le nombre minimum et maximum d'intervenants dans une polyclinique pour une région donnée?

Dr Cushman : C'est une bonne question. Selon la définition médicale classique, il en faut beaucoup plus. C'est le cas à Orléans, où il y a une interface d'environ 20 médecins de famille, de nombreux spécialistes, des services d'IRM, de santé mentale, de toxicomanie, de mammographie, et cetera. Cela pourrait être un mini-hôpital. Voilà un volet. L'autre volet, c'est ce dont nous parlons aujourd'hui, soit ce dont un quartier a besoin. Pour en arriver à l'échelle du quartier, je crois qu'il faut réduire la proportion des services de santé et accroître celle des autres services, les services sociaux et de développement communautaire par exemple.

Il faut des soins médicaux primaires, mais il existe certains avantages à combiner les soins médicaux primaires aux soins spécialisés. Le Centre de santé communautaire Somerset Ouest dispose par exemple de spécialistes à temps partiel. Un psychiatre ou un pédiatre peuvent ainsi venir travailler quelques jours par semaine. Les activités de ce centre sont surtout axées sur les services sociaux, les jardins communautaires et la formation professionnelle.

Pour que tout fonctionne « à la cubaine » et de la façon à laquelle, je crois, vous pensez, il faut que cela se passe à l'échelle du quartier. Il peut y avoir un centre d'intervenants en soins de santé, mais il doit être plus polyvalent sur le plan des services sociaux et du développement communautaire, comme l'a indiqué Mme Mucha.

C'est là une longue réponse pour vous dire que je ne le sais pas vraiment et que cela dépend.

Le président : Qu'ils soient petits ou grands ou comme le modèle d'Orléans, par exemple, il leur manque une chose, comme je l'ai moi-même constaté. Il s'agit de l'intégration avec les services sociaux et de santé publique, qui pourrait également avoir lieu à ce niveau, selon moi. L'Hôpital Montfort qui se décharge de la prestation coûteuse de soins de santé, en quelque sorte.

Entrevoyez-vous la possibilité d'une intégration de certains de ces déterminants sociaux de la santé à la clinique d'Orléans?

Dr. Cushman: That is a good question, because the Orleans clinic will serve 100,000 people. It will be a mini hospital. You can either have a hub-and-spoke model, where you address it in various neighbourhoods in that community, or you have people in a suburban community where there is a lot of travel. People come and go, but, one way or the other, people have to get out. There is the whole business of the travelling public health nurse, visiting home nurse, and so on. You must have equilibrium of this equation.

This is why what Ms. Mucha is talking about is so important. You must understand your neighbourhood and the needs of your neighbourhood. If you are living in a suburban neighbourhood where everyone uses their car every time they go get a litre of milk, you might locate the clinic in a mall and people will come to you. If you are in an urban or rural neighbourhood, you might do it differently. Think about downtown Ottawa and downtown Toronto. They are very different.

I am having trouble with the question because it is hard to see the future. I emphasize that there is the whole sense of quartier and community and neighbourhood. We cannot lose the sense of that. One of the determinants of health is isolation. In this fast world in which we live, we have lost our sense of community. I think back to my nostalgic days as a kid. We fended for ourselves because we had a community that nurtured us. It was a different environment from the one in which I raised my kids. We are paying for this. This is a negative determinant of health that we have created with our material riches. One of the ways to get around that is to go back and drill down in the communities to ensure, for example, that our schools are not being used only from 8:30 a.m. to 4:30 p.m. They are a community resource. We are now selling schools because of the demographics. Yet, they are a resource that belongs with the community. We need to nest these things together. What you nest depends on where you are; whom you are serving; and access, meaning how easy or difficult it is to get the next level of services.

The Chair: You sat in on many city council meetings here in Ottawa in your life as public health officer. I suspect the subject we are talking about, population health, was never addressed. Was it ever addressed?

Dr. Cushman: We looked at it through the health department and working with social services. The City of Ottawa has looked at 60 neighbourhoods. I say 60, but I could be wrong about the number. They are making an effort to concentrate services to move forwards this model rather than provide the same menu of services for all communities. Steve Kanellakos and his group are starting to look at this. Public health, social services, parks and recreation have all played a part. The United Way has also been instrumental. Again, that reminds us of the importance of the non-government and the NGO sectors.

The Chair: It is my impression that the Public Health Agency of Canada, particularly with the clout it has now, is very interested in population health. We will be recommending a major

Dr Cushman : C'est une bonne question, car la clinique d'Orléans desservira 100 000 personnes. Ce sera un mini-hôpital. Il peut s'agir d'une structure en étoile, rayonnant dans les divers quartiers de la collectivité, ou bien d'une banlieue où il y a beaucoup de déplacements. Les gens vont et viennent mais, d'une façon ou d'une autre, ils doivent sortir. C'est là toute la question de l'infirmière de santé publique itinérante, de l'infirmière qui se rend aux maisons, et cetera. Il doit y avoir un équilibre dans cette équation.

C'est pourquoi ce dont Mme Mucha parle est si important. Il faut comprendre son quartier et ses besoins. Si vous vivez dans un quartier de banlieue où chacun utilise sa voiture pour aller acheter un litre de lait, installez votre clinique dans un centre commercial et les gens y viendront. La situation sera peut-être différente en zone urbaine ou rurale. Pensez au centre-ville d'Ottawa ou de Toronto. Ils sont très différents.

Votre question me pose problème, car il est difficile de prévoir l'avenir. Je maintiens qu'il y a toute cette notion de quartier, de communauté, de voisinage. Il ne faut pas la perdre de vue. Un des déterminants de la santé est l'isolement. Dans le monde rapide dans lequel nous vivons, nous avons perdu notre sens de la communauté. Je pense avec nostalgie à mon enfance. Même si nous devons nous débrouiller, nous avons autour de nous une communauté qui veillait à notre bien-être. C'était un environnement différent de celui dans lequel j'ai élevé mes enfants. Nous payons pour cela. Avec notre richesse matérielle, nous avons créé un déterminant négatif pour la santé. Une des façons de régler ce problème consiste à revenir en arrière et à s'implanter davantage dans les communautés afin de s'assurer, par exemple, que nos écoles ne sont pas seulement utilisées de 8 h 30 à 16 h 30. Elles constituent une ressource pour la communauté. Nous mettons nos écoles en vente pour des motifs démographiques. Elles constituent pourtant une ressource qui appartient à la communauté. Il faut en faire des nids. Le nid que l'on construit dépend de l'endroit où on est, de qui on dessert, de la facilité d'accès au niveau de service suivant.

Le président : Vous avez participé à de nombreuses réunions du conseil de la ville d'Ottawa à titre d'agent de la santé publique. J'imagine qu'il n'y a jamais été question du sujet dont nous discutons, la santé de la population. Est-ce le cas?

Dr Cushman : Nous l'avons abordé par l'intermédiaire du service de santé et en travaillant avec les services sociaux. La ville d'Ottawa a répertorié 60 quartiers. Je dis 60, mais je pourrais me tromper. La ville s'efforce de concentrer ses services afin de favoriser ce modèle plutôt qu'un menu de services identique pour toutes les communautés. Steve Kanellakos et son groupe commencent à se pencher sur la question. Les services de santé publique, les services sociaux et des parcs et loisirs ont tous joué un rôle, de même que Centraide. Cela nous rappelle l'importance des organismes non gouvernementaux.

Le président : J'ai l'impression que l'Agence de la santé publique du Canada est très intéressée par la santé de la population, en particulier compte tenu de son influence actuelle.

public health node in PHAC to link to the nodes in the provinces. Hopefully, public health would get linked to communities through the polyclinic concept and so forth.

I can tell you I have raised that with public health officers and it is not necessarily a popular idea. I have asked why there would not be a public health nurse. You cannot have a public health doctor in every polyclinic because the numbers are not there, but you could have a public health nurse there either part time or full time. Why has that concept not caught on?

Dr. Cushman: That is an excellent question. I have been working in population health for most of my career. I am not quite sure I understand it. It is great for the halls of academia. It is wonderful to discuss because it is so meaningful and elegant. I read the Black report when it came out 25 or 30 years ago. Historically we average but, as you know, it worked on the quintiles and we saw the differences in terms of diseases.

One of the problems with respect to poverty, as I said earlier, is that so many of the determinants of health are overwhelming and outside the jurisdiction of our health professionals. Therefore we have to rethink this. As a public health physician, I have looked at a number of these issues. Certain links of the chain you can break with conventional intervention. We have done well on tobacco, but now we are down to 18 per cent of people who smoke, which is so nested in the last quintile. Then we need to get into this community development piece and neighbourhood engagement in getting the services down there.

As Senator Eggleton said, how will we take on poverty? How will we take on education? The isolation is something we can take on. There are a number of things we can take on in terms of building better communities and building the resources. Certainly the late Dan Offord and his group looked at children at risk and there was a sense of resiliency there that we have to tap into.

It is not easy. We have to be flexible, agile and smart. One way is to get into the neighbourhoods, have a dialogue with the people who live there, listen to them and empower them so that we come up with a menu of services they can access.

What bothers me is that we are existential about poverty, and those of the left persuasion talk about it differently than do those of the far right persuasion. I do not care whether you are a bleeding heart missionary or a hard-nosed, calculating accountant; at the end of the day, we cannot afford it. It bites us.

Look at how much money we spend dealing with the consequences of poverty. I suggest it would be cheaper to attack poverty head on. Some of you have been to Cuba; I have not, but to me the real learning piece from there, which I will repeat, is that Cuba has put poverty on its heels. It has addressed the social determinants of health even though the country remains poor. Clearly there are lessons there.

Nous allons recommander la création d'un nœud de santé publique majeur à l'ASPC destiné à être relié aux nœuds provinciaux. Il faut espérer que le concept des polycliniques et autres permette de relier santé publique et collectivités.

Je peux vous dire que j'en ai discuté avec des agents de santé publique et que l'idée n'est pas nécessairement populaire. J'ai demandé pourquoi il n'y a pas d'infirmière en santé publique. Il est impossible d'avoir un médecin en santé publique dans chaque clinique parce qu'ils ne sont pas assez nombreux, mais il pourrait y avoir une infirmière à temps partiel ou à temps plein. Pourquoi n'est-ce pas le cas?

Dr Cushman : C'est une excellente question. J'ai travaillé dans le domaine de la santé publique pendant la majeure partie de ma carrière. Je ne suis pas certain de comprendre. C'est un sujet merveilleux dans les soirées mondaines. Cela paraît bien d'en discuter parce que c'est si signifiant et élégant. J'ai lu le rapport Black lorsqu'il a été publié il y a 25 ou 30 ans. Nous sommes historiquement dans la moyenne mais, comme vous le savez, ce rapport portait sur les quintiles et nous avons constaté les écarts au chapitre des maladies.

Comme je l'ai dit plus tôt, un des problèmes avec la pauvreté est le nombre de déterminants de la santé qui sont écrasants et qui dépassent la compétence de nos professionnels de la santé. Nous devons donc repenser la question. En tant que médecin en santé publique, j'ai examiné un certain nombre de ces déterminants. Il est possible de rompre certains maillons de la chaîne au moyen d'une intervention classique. Nous avons connu un bon succès au sujet du tabac, car nous sommes rendus à 18 p. 100 de fumeurs, ce qui représente le dernier quintile. Nous devons maintenant nous attaquer au développement et à l'engagement communautaire à l'échelle du quartier afin d'y implanter des services.

Comme le sénateur Eggleton l'a dit, comment s'attaquer à la pauvreté? À l'éducation? L'isolement, c'est possible. Nous pouvons poser certains gestes afin de construire de meilleures collectivités et de constituer des ressources. Le regretté Dan Offord et son groupe voyaient dans les enfants à risque une résilience que nous devons exploiter.

Ce n'est pas facile. Nous devons faire preuve de souplesse, d'adresse et d'intelligence. Pour entrer dans les quartiers, il faut tisser des liens avec leurs habitants, les écouter et les habiliter afin de pouvoir leur offrir un menu de services dont ils pourront bénéficier.

Ce qui me tracasse, c'est notre attitude existentielle devant la pauvreté et ceux de gauche qui tiennent à ce sujet un langage différent de ceux de droite. Peu m'importe que vous soyez un missionnaire dans l'âme ou un comptable froid et calculateur. Nous ne pouvons pas nous permettre ce genre de choses. C'est improductif.

Regardez les sommes dépensées à s'occuper des conséquences de la pauvreté. Je pense qu'il serait moins coûteux de s'attaquer de front à la pauvreté. Certains d'entre vous êtes allés à Cuba, pas moi. Ce qu'il faut toutefois retenir, et je l'ai déjà dit, c'est que Cuba a relégué aux oubliettes la pauvreté en tant que déterminant social de la santé même si ce pays reste pauvre. Il est clair que nous devons en tirer des leçons.

The whole notion of drilling down into the neighbourhood and making the services there, involving the community engagement piece and empowering people, is what will give us the answers we need.

Senator Eaton: To pursue what you are saying, Dr. Cushman, I could not agree with you more. Your idea is right and wonderful, but there is a whole part of this country where there are small communities in the North. We almost have to have one system of health for people who live in urban centres or villages or where there are enough people to support a polyclinic and all the attendant neonatal services and whatever you want. Do you see the same system working in the North or do you see another system?

Dr. Cushman: As background, I spent a year working along the Quebec side of Hudson's Bay and James Bay, so I know the Cree and Inuit villages there quite well. They are very small. Some of them are 300 to 400 people. I am showing my age here, but that year was before Hydro Quebec, and some of those villages were isolated. They were fairly self-contained and had traditional ways of doing things. You can compare that with what was on the news recently about the baby who died of meningitis. I did not hear what province that was in, though.

Senator Eaton, you are right on. We see this even within the Champlain LHIN. What is cost-effective in downtown Ottawa will never be cost-effective in Barry's Bay. There is an equity piece there.

Senator Eaton: Maybe we should not worry about it, because there is one pot.

Dr. Cushman: I do not want to wax here; I had better be careful. We all have opinions, and that is not why I am here. However, I was surprised when I heard about this village. I did not have all of the information. I heard a bit over the news. We have to stop learning by our mistakes. If a village is big enough to be a village, maybe it is big enough to have some of these services in an organized way.

I will stop there. However, it gets back to what we said earlier that one-size-fits-all does not work.

Senator Eaton: I have been reading Dr. Leitch's statistics about suicide and diabetes. It is absolutely frightening that we are not addressing this quickly.

The Chair: We are trying.

Ms. Mucha, I have been waiting to get at this. You were the only one today who mentioned the spiritual dimension of determinants of health. I want you to expand on it for two reasons. First, you have a mixed population of native people living on-reserve and native people living off-reserve. We have had the privilege of dealing with them.

I will lead you because I will tell you where our report is right now. We have a different report for the Aboriginal communities than we have for the non-Aboriginal communities because we

C'est cette notion de se rendre jusque dans les quartiers pour y offrir des services, d'engagement communautaire et d'habilitation des gens qui nous fournira les réponses qu'il nous faut.

Le sénateur Eaton : Je suis entièrement d'accord avec vous, docteur Cushman. Votre idée est brillante, mais toute une partie de ce pays, le Nord notamment, est constituée de petites collectivités. Nous sommes presque obligés de disposer d'un système de santé pour ceux qui vivent dans les centres urbains ou les villages où il y a suffisamment de gens pour justifier la présence d'une polyclinique et de tous les services néonataux et autres. Croyez-vous que le même système peut fonctionner dans le Nord?

Dr Cushman : J'ai travaillé pendant un an du côté québécois de la baie d'Hudson et de la baie James. Je connais donc très bien les villages cris et inuits qui s'y trouvent. Ils sont très petits. Certains comptent 300 ou 400 habitants. Je vais quelque peu dévoiler mon âge, mais c'était avant l'arrivée d'Hydro-Québec et certains de ces villages étaient isolés. Ils étaient passablement autosuffisants et faisaient les choses de façon traditionnelle. Vous pouvez comparer cela à cette affaire de bébé mort de la méningite dont il a récemment été question aux nouvelles. Je ne me souviens toutefois pas dans quelle province c'était.

Vous avez raison, sénateur Eaton. Nous voyons même cela dans le RLISS de Champlain. Ce qui est rentable au centre-ville d'Ottawa ne le sera jamais à Barry's Bay. Il y a un élément d'équité.

Le sénateur Eaton : Il ne faut peut-être pas s'inquiéter, car il y a une seule source de financement.

Dr Cushman : Je ne veux pas m'emporter; je dois être prudent. Nous avons tous nos opinions, mais ce n'est pas la raison de ma présence ici. J'ai toutefois été surpris d'entendre la nouvelle au sujet de ce village. Je ne dispose pas de toute l'information. J'en ai entendu une partie aux nouvelles. Nous devons cesser de tirer des leçons de nos erreurs. Si un village est assez gros pour être un village, il est peut-être assez gros pour abriter certains services de façon organisée.

Je vais m'arrêter ici. Cela revient toutefois à ce dont nous avons discuté plus tôt. Une solution unique ne convient pas à toutes les situations.

Le sénateur Eaton : J'ai lu les statistiques de la Dre Leitch au sujet du suicide et du diabète. C'est absolument terrifiant que nous n'agissions pas rapidement.

Le président : Nous essayons.

Madame Mucha, j'attendais d'aborder le sujet. Vous êtes la seule aujourd'hui à avoir parlé de la dimension spirituelle des déterminants de la santé. J'aimerais que vous nous en disiez plus pour deux raisons. D'abord, vous avez une population d'Autochtones vivant dans les réserves et à l'extérieur des réserves. Nous avons eu le privilège de nous pencher sur leur cas.

Je vais vous aider en vous disant où nous en sommes dans notre rapport. Nous avons préparé un rapport pour les collectivités autochtones et un autre pour les collectivités non

think they are different and have to be organized differently. Then there is the complex problem that 60 per cent of Aboriginal people are now living off their native lands or their native communities, off the reserves if they are First Nations.

We will be making recommendations around the polyclinic, which embraces all of the determinants of health and is not that different from what you are doing already. How are you getting application of your ideas and methodologies in both of these dimensions, in dealing with Native people off-reserve and Native people on-reserve?

Ms. Mucha: I would like to suggest there is even more complexity than that. In B.C., we are experiencing that it is not just non-Native and Native, but the reserves also have a great deal of diversity in cultural backgrounds. There are different cultures within the Native populations, as well. That brings in a whole other dimension to how we do our work.

In our model, we talk about this upper left quadrant as the psychological and spiritual, in which certain determinants are categorized. Depending on the groups we work with, we may never use the word spirituality. We are really talking about values. I was saying earlier that the focus is the whole person and the whole community. The whole person is multi-dimensional; it is inside and who I am and what views I bring to the table. It is also what I take away from each of you in my experience. It is the interior and the exterior of the individual, and this plays into the human development piece.

We have worked with several First Nations groups. Again, depending on how we work with communities, we may come to the table right away and share with them a model that we can use for a process to work with them or there might be a time when there is an entry point to begin talking about it. They are already leading us along the way. People are saying, "You are actually showing me a model that represents what I am already trying to talk about and I have not really had words or a way of communicating it."

The First Nation group I am speaking of were quite excited when they did see our model because it resonated with them and was similar to their medicine wheel. They took the two and basically revised the medicine wheel for decision making in their community to incorporate some aspects that were not there previously.

In those cases, there is a strong indication and acknowledgement that, "This rings true; this makes sense; this gives our philosophies and our thinking some legs." Again, the groups coming to us are groups that are interested in taking more of an integrated, holistic perspective.

I am not saying that all are willing. However, the ones we work with are the ones that approach us. I think if you can create critical mass that way, word gets out, interest is piqued and people start seeing the results: financial results, community results with crime prevention, where community safety is increased, and

autochtones, car nous croyons qu'elles sont différentes et qu'elles doivent s'organiser différemment. Il y a aussi le problème complexe lié au fait que 60 p. 100 des Autochtones vivent maintenant loin de leurs terres ancestrales ou de leur collectivité d'origine, ou à l'extérieur des réserves s'ils font partie des Premières nations.

Nous allons émettre des recommandations au sujet de la polyclinique, qui englobe tous les déterminants de la santé et qui ne diffère pas de ce que vous faites déjà. Comment appliquez-vous vos idées et vos méthodes à ces deux réalités des Autochtones vivant dans les réserves et à l'extérieur des réserves?

Mme Mucha : Je dirais que la question est plus complexe que cela. Nous constatons qu'en Colombie-Britannique ce n'est pas seulement une question d'Autochtones et de non-Autochtones. Il existe une grande diversité culturelle au sein même des réserves. Les populations autochtones ont également des cultures différentes entre elles. Cela apporte une toute autre dimension à la façon dont nous accomplissons notre travail.

Dans notre modèle, nous parlons du quadrant supérieur gauche comme de la partie psychologique et spirituelle, dont font partie certains déterminants. Il se peut que, selon les groupes avec lesquels nous travaillons, nous n'utilisions jamais le mot spiritualité. Nous parlons de valeurs. Je disais plus tôt que l'accent est mis sur l'ensemble de la personne et de la collectivité. La personne est multidimensionnelle. C'est mon for intérieur, qui je suis et ce que j'apporte à la table. C'est aussi tout ce que j'obtiens de chacun d'entre vous dans le cadre de mon expérience. C'est l'intérieur et l'extérieur de l'individu, et cela joue un rôle dans l'élément du développement humain.

Nous avons travaillé avec plusieurs groupes des Premières nations. Je le répète, selon la façon dont nous travaillons avec les collectivités, il est possible que nous arrivions d'emblée à la table en leur présentant un modèle pouvant leur être utile, ou que nous attendions une ouverture nous permettant d'aborder le sujet. Les collectivités nous aiguillent déjà. Des gens nous disent : « Vous nous montrez un modèle qui représente ce que je tente d'exprimer, mais je ne disposais pas des mots ou des moyens pour le faire. »

Le groupe des Premières nations dont je parle a été très enthousiasmé de voir notre modèle, car il leur évoquait quelque chose. Il était semblable à leur roue médicinale. Ils ont pris les deux et ont en fait adapté la roue médicinale dans un but décisionnel pour leur collectivité afin d'y intégrer des aspects qui n'y étaient pas auparavant.

Dans ces cas, on nous dit très clairement des choses comme « c'est vrai, ça a du bon sens, ça donne du poids à notre philosophie et à notre façon de penser ». Je le répète, les groupes qui s'adressent à nous cherchent à adopter une approche plus intégrée, plus holistique.

Je n'affirme pas que tous les groupes ont cette attitude. Toutefois, ceux avec qui nous travaillons sont ceux qui nous approchent. Je crois que si on crée ainsi une masse critique, la nouvelle se répand, l'intérêt est piqué et les gens commencent à constater des résultats : résultats sur le plan des finances et de la

intergenerational connections are formed, and so on. Communities are very interested. They want their community to be like that.

The Chair: I want to know what your interface is with crime prevention, because that is also a huge dimension of population health. Since you have only a couple of minutes, I want to know how you are linking with Health Canada and Indian and Northern Affairs Canada to deal with Native people.

Ms. Mucha: We have had some preliminary conversations, but we have not been working closely with them yet. There are many organizations and agencies we need to be talking with to expand on what we are doing and communicate the results. We are evaluating our initiative now using this integrated evaluation framework and we can communicate the results so that we can show more.

We are working with communities to tell their story. As you know, it takes time to be able to illustrate the quantitative results. Qualitative results in the case of community development work, in particular, are very important. There are "Aha!" moments—those moments when the community will never be the same; they realize that there is another way of doing things and now an opening occurs.

Therefore, we are working with them to tell their story through the means of digital storytelling. This is a way that we can more concretely provide some results of the work that we are doing when we do approach and dialogue with other agencies in terms of what we are doing and what it actually looks like on the ground.

Again, we do this because we are selling a process, not a program. It has taken a few years to start seeing some themes and some different results out of how that process unravels in the different communities.

The Chair: I visited the Vancouver Aboriginal Friendship Centre on Hastings Street and I got the impression that the Native peoples using that centre had pretty well fallen through the cracks. They did not have anyone to look after them because they were off-reserve and they were not part of the other system in Vancouver, although it was impressive. We brought in by teleconference the authorities from the Vancouver —

Ms. Mucha: — community project?

The Chair: Regardless, they are truly impressive people, so I am sure that the Native people could find their way into that dimension and network. However, if you walk through the friendship centre and talk to some of them and ask them who is looking after them, they fundamentally say that no one is.

Ms. Mucha: We do have a First Nations representative from a provincial First Nation. That brings the provincial scope to the table in our planning and thinking. As I said earlier, we are working with First Nations groups; they are approaching us. We do not have a mandate to target certain populations. However,

prévention de la criminalité dans la collectivité, hausse du sentiment de sûreté dans la collectivité, création de liens intergénérationnels, et cetera. Les collectivités sont très intéressées. Elles veulent être semblables à cela.

Le président : J'aimerais connaître votre approche en matière de prévention de la criminalité, car cela constitue également un aspect très important de la santé de la population. Comme il ne vous reste que quelques minutes, j'aimerais savoir quelles sont vos relations avec Santé Canada et Affaires indiennes et du Nord Canada en ce qui concerne les Autochtones.

Mme Mucha : Nous avons eu des conversations préliminaires, mais nous n'avons pas encore travaillé étroitement avec ces ministères. Nous devons traiter avec bien des organismes et des agences afin d'expliquer ce que nous faisons et de communiquer nos résultats. Nous évaluons notre initiative en ce moment grâce à ce cadre intégré d'évaluation et nous pouvons communiquer les résultats afin d'en montrer davantage.

Nous travaillons avec les collectivités afin de raconter leur histoire. Comme vous le savez, il faut du temps pour illustrer les résultats quantitatifs. En ce qui concerne le développement communautaire en particulier, les résultats qualitatifs sont très importants. Il y a des moments d'émerveillement, à partir duquel la collectivité ne sera plus jamais la même, ces moments où les gens réalisent qu'il existe une autre façon de faire et qu'ils entrevoient une solution.

Nous travaillons donc avec les collectivités afin de raconter leur histoire grâce à l'informatique. C'est un moyen pour nous de présenter de façon plus concrète certains de nos résultats lorsque nous approchons d'autres agences et leur décrivons notre travail sur le terrain.

Je le répète, nous faisons cela parce que nous faisons la promotion d'un processus et non un programme. Il a fallu quelques années avant de commencer à voir des thèmes et des résultats différents en fonction des diverses collectivités.

Le président : J'ai visité le Vancouver Aboriginal Friendship Centre sur la rue Hastings et j'ai eu l'impression que les Autochtones qui fréquentent ce centre sont plus ou moins tombés entre les mailles du filet. Personne ne s'occupait d'eux parce qu'ils étaient à l'extérieur de leur réserve et qu'ils ne faisaient pas sous la juridiction de l'autre système à Vancouver, même si c'était impressionnant. Nous avons organisé une téléconférence avec les responsables du projet...

Mme Mucha : ... communautaire de Vancouver?

Le président : Peu importe. Ce sont vraiment des gens impressionnants. Je suis persuadé que les Autochtones pourraient s'y retrouver. Toutefois, allez au Centre et parlez à certains d'entre eux. Ils vous diront que personne ne s'occupe d'eux.

Mme Mucha : Nous avons un représentant d'une Première nation de la province. Cela apporte un point de vue provincial à notre table de planification et d'élaboration. Comme je l'ai dit plus tôt, nous travaillons avec des groupes des Premières nations. Ils viennent nous voir. Nous n'avons pas le mandat de cibler

again, it is to ensure that those different populations and those sectors are at the table and involved, that their voice is heard and that we are engaging with those groups in communities we work with.

The Chair: Thank you both very much for coming to speak with us.

We will now hear the testimony of Dr. Kellie Leitch, who did an extensive report for the Minister of Health at the time. It has been widely circulated in Canada and has been the subject of much discussion and many compliments. Please tell us about it.

Dr. Kellie Leitch, as an individual: Thank you very much for having here. I will start with a statement with respect to the report, and then I am happy to take questions.

Mr. Chairman, honourable senators, thank you for allowing me to speak to you today. I will share the principal conclusions of my report on the health and wellness of Canadian children and youth, entitled *Reaching for the Top*. I think it was circulated to you, in both English and French, so I hope you had an opportunity to see it.

In March 2007, I was asked by the then Minister of Health, the Honourable Tony Clement, to provide advice to the federal government on improving the health of Canada's children and youth. It is both an honour and a privilege to help shape public policy when it comes to the health and wellness of children. It is also something I take very seriously, largely due to my day job. I work as a pediatric orthopaedic surgeon, encountering children with illness and primarily injuries from falling off swing sets and such every day.

In writing this report, I traveled to every province and territory in the country. I learned that getting the health and wellness of our children right is an absolutely essential ingredient to the success of our country. Nations like India, China and others in Southeast Asia and Eastern Europe are investing tremendously in health care and education for children and youth. They are investing because they get that the number one source of long-term sustainable competitive advantage for their nations is investing heavily in the health, education and training of their young people. In Canada, we must take a similar perspective, not only because it is good social policy to invest in the health of our children, but because it is good economic policy.

We have the resources and wherewithal to succeed, but, as I have stated in my report, Canada has significant opportunity to improve. My report contains a total of 95 recommendations on how to help children to be healthier so that they can live better, happier and more productive lives.

Throughout my research, I learned that we need to invest in the health and wellness of our children and youth in the same way we invest in infrastructure, science and technology. They are our future, and they are fundamental to the nation's economic success

certaines populations. Toutefois, je le répète, nous devons nous assurer que ces différentes populations et ces différents secteurs soient représentés à la table, qu'ils participent, que leur voix soit entendue et que nous traitions avec ces groupes dans les collectivités avec lesquelles nous travaillons.

Le président : Merci beaucoup à vous deux d'être venus nous parler.

Nous allons maintenant entendre le témoignage de la Dre Kellie Leitch, qui avait à l'époque produit un rapport exhaustif pour le ministre de la Santé. Ce rapport a beaucoup circulé au Canada et a fait l'objet de nombreuses discussions et de bien des compliments. Veuillez nous en dire plus.

Dre Kellie Leitch, à titre personnel : Merci beaucoup de me permettre d'être ici aujourd'hui. Je vais d'abord vous parler du rapport, après quoi il me fera plaisir de répondre à vos questions.

Monsieur le président, honorables sénateurs, je vous remercie de me permettre de m'adresser à vous aujourd'hui. J'aimerais vous présenter les principales conclusions de mon rapport sur la santé et le bien-être des enfants et des jeunes du Canada, intitulé *Vers de nouveaux sommets*. Je crois qu'il vous a été distribué en anglais et en français. J'espère que vous aurez l'occasion de le lire.

En mars 2007, le ministre de la Santé de l'époque, l'honorable Tony Clement, m'a demandé de conseiller le gouvernement fédéral sur la façon d'améliorer la santé des enfants et des jeunes du Canada. C'est à la fois un honneur et un privilège de participer à l'élaboration de la politique publique quand il est question de la santé et du bien-être des enfants. Cet enjeu me tient également beaucoup à cœur, principalement en raison de ma profession, soit celle de chirurgienne orthopédiste pédiatrique. Dans le cadre de mes fonctions, je rencontre quotidiennement des enfants malades et surtout blessés à la suite d'une chute de balançoire, par exemple.

Pour préparer mon rapport, je me suis rendue dans chaque province et territoire. J'ai constaté que la santé et le bien-être de nos enfants est absolument essentielle à la réussite de notre pays. Des pays comme l'Inde, la Chine et d'autres pays d'Asie du Sud-Est et d'Europe de l'Est investissent massivement dans les soins de santé et l'éducation pour les enfants et les jeunes. Ces pays investissent parce qu'ils comprennent que leur premier avantage concurrentiel à long terme résidera dans une jeunesse en santé, scolarisée et qualifiée. Le Canada doit adopter un point de vue semblable. Non seulement l'investissement dans la santé des enfants constitue-t-il une bonne politique sociale, il s'avère aussi une bonne politique économique.

Nous possédons les ressources nécessaires pour réussir, mais comme je l'ai indiqué dans mon rapport, le Canada a beaucoup de choses à améliorer. Mon rapport contient un total de 95 recommandations pour faire en sorte que les enfants soient en meilleure santé, afin qu'ils puissent vivre mieux et qu'ils soient plus heureux et productifs.

Tout au long de ma recherche, j'ai pris conscience que nous devons investir dans la santé et le bien-être de nos enfants et de nos jeunes au même titre que nous investissons dans les infrastructures, la science et la technologie. Ils représentent

in an increasingly competitive world. For a nation that prides itself on being prosperous, generous and enlightened, we actually must do much better.

Today I would like to talk to you about three key issues and opportunities that I identified in my report: injury prevention, childhood obesity and mental health.

The first of these three issues is injury prevention. Preventable injuries are the number one cause of death among Canadian children and youth. I encourage you to think about that. Injuries to children cost the Canadian economy \$4 billion per year. Clearly, there is significant progress to make in preventing injuries among children.

In my report, I recommend that the federal government establish a national injury prevention strategy, a five-year national strategic plan following in the footsteps of the United Kingdom, the Netherlands, Sweden and many others that have done exactly the same thing with excellent results. I also make recommendations on issues like supporting helmet use, eliminating toxic toys, and promoting booster seats and other protective equipment for children and youth. We need to put the large national injury prevention strategy in place first, but follow it up and support it with initiatives that tackle specific problems. That is how we will actually get these numbers down.

The second issue I will speak about is childhood obesity. The percentage of overweight children in Canada has tripled in the last generation. Today, 15 per cent of Canadian children are overweight and obese, and another 30 per cent to 40 per cent are at risk of becoming that. In fact, obesity is the new tobacco for Canadian children in this generation.

There are a number of causes, and I think we all know them. They are all interconnected, including bigger food portions and, quite frankly, too much PlayStation and not enough playground. Overweight children are at risk of diabetes and cardiovascular disease and will continue to have these chronic comorbidities into adulthood, putting even more pressure on a health care system working as hard as it can to accommodate aging baby boomers. Many of these children will actually die of these chronic diseases.

In my report, I recommend the establishment of a centre of excellence on childhood obesity. This centre would bring together experts in fields like nutrition, physical activity, child care and others to establish national standards and programs to help fight childhood obesity. I have also recommended that the federal government establish an obesity target. We need to get the rates of childhood obesity down from 8 per cent to 5 per cent by 2015.

The last issue I will touch on is mental health. Children with mental health problems are often identified and referred into this system way too late in this country, and their problems worsen with time. They are simply not getting the opportunities that

notre avenir, et ils sont essentiels à la réussite économique de notre pays dans le monde de plus en plus concurrentiel où nous vivons. À titre de nation qui se targue d'être prospère, généreuse et éclairée, le Canada peut, et doit, faire beaucoup mieux.

J'aimerais vous entretenir aujourd'hui de trois enjeux prioritaires et des occasions connexes cernés dans mon rapport : il s'agit de la prévention des blessures, de l'obésité infantile, et de la santé mentale.

Le premier enjeu est la prévention des blessures. Les blessures évitables représentent la première cause de mortalité chez les enfants et les jeunes du Canada. Pensez-y. Les blessures subies par les enfants coûtent 4 milliards de dollars par année à l'économie canadienne. Il y a donc beaucoup de place à l'amélioration dans ce domaine.

Dans mon rapport, je recommande au gouvernement fédéral d'établir un plan quinquennal stratégique national de prévention des blessures, à l'image de ceux adoptés par le Royaume-Uni, la Suède et les Pays-Bas et bien d'autres pays, et qui ont produit d'excellents résultats. Je fais également des recommandations sur des questions comme l'appui au port du casque, l'élimination des jouets toxiques et la promotion des sièges d'appoint et de l'équipement protecteur pour les enfants et les jeunes. Nous devons mettre en œuvre une stratégie nationale de prévention des blessures, puis la soutenir au moyen d'initiatives visant à régler des problèmes particuliers. Voilà comment nous pourrions améliorer la situation.

Le deuxième enjeu dont je veux discuter avec vous aujourd'hui est l'obésité infantile. Le pourcentage d'enfants en surpoids au Canada a triplé en une génération. Aujourd'hui, 15 p. 100 des enfants canadiens ont un excès de poids, et de 30 à 40 p. 100 risquent d'en avoir un. Le problème de l'obésité est, pour la génération actuelle d'enfants canadiens, l'équivalent du problème du tabac pour les générations précédentes.

Ce phénomène s'explique par un certain nombre de facteurs, et je pense que nous les connaissons tous. Ces facteurs sont interreliés. Ils comprennent l'augmentation des portions de nourriture, trop de jeux vidéo et pas assez de jeux à l'extérieur. Les enfants en surpoids risquent de développer des maladies cardiovasculaires et le diabète, et ils continueront de souffrir de ces comorbidités chroniques à l'âge adulte, ce qui mettra encore plus de pression sur un système de soins de santé qui peine déjà à s'occuper des bébé-boumeurs vieillissants. Bon nombre de ces enfants mourront de ces maladies chroniques.

Dans mon rapport, je recommande l'établissement d'un centre d'excellence sur l'obésité infantile. Ce centre réunirait des experts de domaines comme la nutrition, l'activité physique et les soins aux enfants, en vue d'établir des normes et des programmes de lutte contre l'obésité infantile. Je recommande également au gouvernement fédéral de fixer un objectif pour la diminution de l'obésité infantile au Canada. Nous devons faire passer le taux d'obésité infantile de 8 à 5 p. 100 d'ici 2015.

Le dernier enjeu principal que je veux aborder avec vous aujourd'hui est la santé mentale des enfants. Chez les enfants, les troubles mentaux sont souvent diagnostiqués trop tard, ce qui retarde la prise en charge par le système de santé et entraîne

other Canadian children receive. The good news is that if we catch pediatric mental health problems early enough, we can help these children lead happy, productive lives, but if we do not, their problems actually become society's problems.

A major recommendation in my report is the establishment of a pediatric mental wait time strategy. Right now, we actually do not even know how long children are waiting for mental health services in this country, let alone how effective they are or what type of access they have. We need to identify problems and bottlenecks in the mental health system and focus our efforts in ensuring timely access to care.

No country in the world has the resources we have in health, nor the talent and potential that Canada has. It will take planning and a desire to change long-standing systems, but most importantly it will take a commitment from all of us to take some action on these items. My report provides a path and points a way for Canada to become a global leader in child and youth health. For each of the key factors I talked about this evening — injury prevention, childhood obesity, and mental health — there are actions that can and must be taken in order to make a difference.

No great achievement was ever accomplished that had a timid goal. I would encourage us to have the same goal together in establishing Canada as the number one place in the world for a child to grow up.

Thank you very much for your time. I would be happy to take any of your questions.

The Chair: Thank you very much, Dr. Leitch. A number of senators would like to ask you questions.

[Translation]

Senator Pépin: I will speak in French but you can answer in English. When you spoke about having a wait time strategy for children suffering from mental illness, I did not realize that the wait times were so long. I knew there were problems. You believe it is one of the main causes. If we could provide care earlier, could we help some of them?

[English]

Dr. Leitch: Yes, the statistics in Canada are that one in five children has access to mental health services in the time frame they should be received — only 20 per cent. For the majority of children, we do not even know the time frame, nor have the benchmarks been set for when they should be seen. What we have done in this country, which I think is commendable, in my own

aggravation of the disease as the child grows. Children who are not given access to mental health services as early as possible miss out on the opportunities that children in Canada have. From a more optimistic point of view, by diagnosing mental health problems in children as early as possible, we can help them become happy, productive adults. When we fail to do this, their problems become society's problems.

Une recommandation majeure contenue dans mon rapport est l'élaboration d'une stratégie relative aux délais d'attente pour les services pédiatriques de santé mentale. À l'heure actuelle, nous ignorons la durée des délais d'attente pour les services pédiatriques de santé mentale. Nous connaissons encore moins l'efficacité de ces services et nous n'avons pas de description des mécanismes permettant d'y accéder. Nous devons cerner les problèmes et les sources de congestion dans le système de santé mentale et orienter nos efforts en vue d'offrir un accès rapide aux services.

Aucun autre pays ne possède autant de ressources, de talent et de potentiel que le Canada dans le domaine de la santé. Nous devons effectuer une bonne planification et être animés par le désir de changer des systèmes qui sont en place depuis bien longtemps. Mais avant tout, nous devons tous nous engager à agir. Mon rapport trace une voie vers l'avenir et établit une orientation qui permettrait au Canada de devenir un chef de file à l'échelle mondiale dans le domaine de la santé des enfants et des adolescents. Pour chacun des facteurs clés dont j'ai parlé ce soir, c'est-à-dire la prévention des blessures, l'obésité infantile et la santé mentale des enfants, certaines mesures peuvent, et doivent, être prises pour améliorer la situation.

Aucune grande réalisation ne découle d'un objectif modeste. Tâchons donc de nous fixer l'objectif commun de faire du Canada l'endroit dans le monde où les enfants trouvent les meilleures conditions pour assurer leur croissance.

Merci beaucoup pour le temps que vous m'avez accordé. Je serai maintenant heureuse de répondre à vos questions.

Le président : Je vous remercie beaucoup, docteure Leitch. Il y a des sénateurs qui aimeraient vous poser des questions.

[Français]

Le sénateur Pépin : Je vais parler français mais vous pouvez me répondre en anglais. Lorsque vous dites qu'il faudrait avoir une stratégie pour les temps d'attente pour les enfants qui souffrent de maladie mentale, je ne savais pas que notre temps d'attente était si long en fait. Je savais qu'il y avait des difficultés. Vous croyez que c'est l'une des causes fondamentales. Si on était capable de faire suivre les enfants au plus tôt, à ce moment, on pourrait en récupérer plusieurs?

[Traduction]

Dre Leitch : Oui, selon les statistiques au Canada, un enfant sur cinq ayant besoin de services de santé mentale y a accès dans un délai acceptable. C'est seulement 20 p. 100. Pour la majorité des enfants, on ne connaît même pas les délais. Nous n'avons pas non plus de critères permettant de savoir quels seraient les délais acceptables. Nous avons établi, dans le domaine de la chirurgie,

field of surgery, is establish a national pediatric surgical wait time. We have set the benchmarks and the time frame, and now all of us working in child surgical health are working to achieve those, and we are driving numbers down. For dentistry access, or access for children to get tubes in their ears, we have decreased wait times in this country from 18 months to 12 months in most provinces. I believe that we must set the benchmarks for mental health access for children, and then we must implement a plan to drive towards it so that the 80 per cent of children who do not have timely access actually receive it. We know that the 70 per cent who receive it when they are young lead productive adult lives. It makes a huge difference, and we need to tackle that.

[Translation]

Senator Pépin: I am somewhat disturbed by the fact that the leading cause of death among children is related to a preventable injury. Can you tell me more about this? What kind of injuries are we talking about?

You stated that Sweden and the Netherlands have a law or regulations to that effect. Could you elaborate on that point?

[English]

Dr. Leitch: As a pediatric orthopaedic surgeon, I see children every day who have been in severe accidents. The numbers astound me. Canada ranks 22 out of 29 countries in the Organisation for Economic Co-operation and Development, OECD, for preventable injuries causing death. I have outlined in the report the details of what I have termed the 15 killers of kids.

The number one killer is motor vehicle-related accidents, which may involve a booster seat or car seat; teenagers who are driving early and unsafely; or a pedestrian hit by a vehicle or a child on a bike hit by a vehicle.

The second leading cause after motor vehicle involvement with a child is drowning and suffocation. It is astounding that in this country one in 230 children who are admitted to an emergency department, and not just because they broke an arm or had a small fall, are admitted overnight. Twenty per cent of those have head injuries that leave them with lifelong disabilities. These are astounding statistics in a country like ours. They should not occur. We do a great job once children come through the door at academic teaching hospitals like my own, but we should not be seeing them. I would quite happily be put out of business.

As has been done in many European states, we need to put in place a national injury prevention strategy that focuses on a number of things, one being leadership. We have done a great job

qui est mon domaine, des délais à ne pas dépasser pour les enfants en attente d'une opération chirurgicale au pays, ce qui est louable. Nous avons établi des critères et des délais à ne pas dépasser. Tous les gens qui œuvrent dans le domaine de la chirurgie pédiatrique s'emploient désormais à respecter ces critères et ces délais, ce qui fait diminuer les temps d'attente. Pour les opérations de chirurgie dentaire ou pour les enfants qui ont besoin de se faire poser des mèches dans les oreilles, nous avons fait passer les temps d'attente de 18 à 12 mois dans la plupart des provinces. Je crois que nous devons fixer des critères pour l'accès des enfants aux soins de santé mentale. Puis, nous devons mettre en œuvre un plan en vue de respecter ces critères, de telle sorte que les enfants qui n'ont pas accès à ces soins dans un délai acceptable, soit 80 p. 100 des enfants concernés, puissent y avoir accès. Nous savons que 70 p. 100 des enfants qui ont besoin de tels soins deviennent des adultes productifs s'ils les reçoivent lorsqu'ils sont jeunes.

[Français]

Le sénateur Pépin : Je suis quelque peu estomaquée de voir que la première cause de décès chez les enfants est liée à une première blessure. Pouvez-vous m'en dire plus à ce sujet? Quelle sorte d'accident arrive-t-il?

Vous dites que la Suède et les Pays-Bas ont une loi ou un règlement à cet effet. Pourriez-vous élaborer sur ce point?

[Traduction]

Dr. Leitch : En tant que chirurgienne orthopédique spécialisée en pédiatrie, je vois tous les jours des enfants qui ont subi des accidents graves. Les chiffres sont renversants. Le Canada est au 22^e rang sur 29 pays de l'Organisation de coopération et de développement économique ou OCDE, pour ce qui est des blessures évitables causant la mort. Je donne dans le rapport les détails sur les 15 causes de mortalité accidentelle parmi les enfants.

Les accidents de la route sont la première de ces causes. Tantôt, c'est un siège d'appoint ou un siège d'enfant dans l'automobile qui est en cause, tantôt ce sont des adolescents qui prennent le volant alors qu'ils sont encore jeunes et qui conduisent dangereusement, tantôt c'est un véhicule qui frappe un enfant à pied ou à vélo.

Les noyades et les suffocations sont la deuxième cause de décès accidentel parmi les enfants. Il est renversant d'apprendre qu'au pays, un enfant sur 230 admis à l'urgence, pas seulement à cause d'un bras cassé ou d'une petite chute, est admis la nuit. Vingt pour cent des enfants qui subissent une blessure à la tête en gardent des séquelles la vie durant. Ce sont des statistiques renversantes pour un pays comme le nôtre. Ce sont des accidents qui ne devraient pas se produire. Nous faisons un travail formidable lorsque des enfants viennent se faire traiter dans un hôpital universitaire comme le mien, mais nous ne devrions pas avoir à les traiter. Je serais tout à fait heureuse de manquer de travail.

À l'instar de nombreux pays européens, nous devons nous doter d'une stratégie nationale de prévention des blessures qui met l'accent sur un certain nombre de choses, y compris de ne pas

in this country on smoking, litter and other things where the nation has shown leadership and the Government of Canada has shown leadership in driving change.

We need good social marketing. We need to educate parents and children on what the problems are and how they can fix them. We need to provide national standards in that strategy of what we need to achieve. We need to collaborate not only among academics, but among industry and NGOs like the YMCA and the Boys and Girls Club. We need to ensure that our colleagues in the NGO world are communicating and that we have the appropriate research to back what we are doing in an evidence-based way.

In the report I tried to detail those components that have been used in other jurisdictions that we could implement here to have a resounding impact on changing the dial for kids.

Senator Eaton: Dr. Leitch, this is a wonderful and very interesting report. One thing that comes out of this report is that we have process and government, but none of it seems to be working or interconnecting. It is all very siloed.

Before your appearance here today we were talking about polyclinics in communities that would look after primary and maybe neonatal health and, if it was an elderly community, having special things for the older generations. Do you envision a polyclinic-type model that could do childhood care or deal with obesity prevention? Could we use schools or workplaces to teach people prevention and nutrition care?

Dr. Leitch: There are a few mechanisms that could be utilized very well to have that comprehensive care approach. Canadian parents were adamant with me about what we need to focus on, that being these three big items: injury prevention, obesity and mental health. I was astounded at how consistent this was across the country. In our online, five-day survey, 7,200 parents said exactly the same thing.

I think you can create a mechanism that focuses on kids that is like the polyclinic you speak of, but I think the best way of accessing children is through the school system, because they are a captive audience. They are there all the time and they are a ready audience.

For those kids who are more challenging to reach, and also for parent education, I recommended in the report an annual national report card similar to the immunization record, that yellow card that every parent has on which they check all the boxes. There are certain things that every child should have —

avoir peur d'agir en chef de file. Nous avons accompli de grands progrès au pays concernant la réduction du tabagisme, la réduction des déchets et d'autres problèmes parce que le pays a agi en chef de file, parce que le gouvernement a agi en chef de file pour provoquer des changements.

Il nous faut de la bonne mercatique sociale. Nous devons éduquer parents et enfants pour leur faire comprendre les problèmes et leur montrer les solutions afin d'y remédier. Nous devons baliser la stratégie avec des normes nationales et définir les résultats à obtenir. Nous devons collaborer, et la collaboration doit se faire non seulement entre universitaires, mais aussi avec les acteurs de l'industrie et avec les ONG telles que l'Alliance universelle des unions chrétiennes de jeunes gens et les Clubs garçons et filles du Canada. Nous devons veiller à ce que nos collègues dans le monde des ONG prennent part à la communication. Nous devons veiller aussi à ce que notre travail sur le terrain puisse s'appuyer sur des données issues de la recherche.

Dans le rapport, j'ai essayé de décrire les éléments qui ont été utilisés ailleurs dans le monde et auxquels nous pourrions avoir recours au pays pour améliorer considérablement les perspectives des enfants en matière de santé.

Le sénateur Eaton : Docteur Leitch, voilà un rapport merveilleux et très intéressant. Il en ressort notamment que nous avons une mécanique et un gouvernement, mais que tout cela semble ne pas fonctionner et que les interconnexions ne se font pas. Tout se fait en vases clos.

Avant votre témoignage d'aujourd'hui, nous parlions des polycliniques locales qui s'occuperaient des soins primaires et de la santé néonatale et qui, dans les milieux où les personnes âgées sont présentes, leur offriraient des services particuliers. Pensez-vous que le modèle de la polyclinique serait utile pour offrir des soins pédiatriques ou faire de la prévention de l'obésité? Pourrions-nous nous servir des écoles ou des milieux de travail pour faire de l'éducation populaire axée sur la prévention et la nutrition?

Dre Leitch : Il existe des mécanismes qui seraient très utiles pour mettre en œuvre une approche globale en matière de soins de santé. Les parents canadiens sont tout aussi catégoriques que moi quand vient le temps de définir les priorités, qui sont au nombre de trois : la prévention des blessures, l'obésité et la santé mentale. J'ai été renversée de voir jusqu'à quel point le constat est le même dans l'ensemble du pays. Les 7 200 parents qui ont répondu à notre enquête en ligne d'une durée de cinq jours ont dit exactement la même chose.

Je pense qu'on pourrait créer un mécanisme axé sur les enfants qui serait semblable à la polyclinique dont vous parlez. Toutefois, je pense que le meilleur moyen d'atteindre les enfants est de passer par le système scolaire, où ils constituent un public captif. Ils y sont constamment et y sont prêts pour nos interventions.

Pour les enfants qui sont plus difficiles à atteindre et aussi pour éduquer les parents, je recommande dans le rapport un bilan annuel d'examen pour enfants employé partout au pays qui serait semblable au dossier d'immunisation, c'est-à-dire la fiche jaune sur laquelle les parents doivent cocher toutes les cases. Tout

optical care, dental care and certain other things, such as those you are talking about in a polyclinic. If we provided that tool to parents, it would empower them to help their kids. We have to provide the resources and services to do that.

Much of that sits with the provinces. In the case of First Nations and Inuit health, it sits with the federal government. There are very few mechanisms that tie them together. The first part is empowering parents, giving them the checklist of things they need to do for their kids so that they know, because many of them do not.

Senator Eaton: You were talking about smoking and litter, and I absolutely agree. Do you foresee us beginning, for example, a national campaign on diabetes, eye care or prevention? Does a grassroots national campaign with ads work?

Dr. Leitch: On the preventive side, the federal government can have a huge impact in that way, but I would not pick a disease entity. I would pick obesity components or injury prevention, because if we are ahead of the curve in ensuring that children are not injured and therefore not coming to the emergency department, there will be huge savings. The saying is, "Look a little ahead, my friend." If we look a little ahead and work on the preventive side, we will save both economically and in social infrastructure.

You can have national campaigns. The federal government has a huge impact. I have said at many tables where I have met with ministers, and I will repeat it here, that you have a huge opportunity. The country will follow you. You did it with tobacco, and you have done it with other things. Pick the big items you can move, because you can do it. Invest in them and move the dial.

This country should never see a child at the emergency department because they drowned. In this country a child should never come through the emergency department and be diagnosed with type 2 diabetes at age five. Those things should not occur in this country.

You have the capability, as a national body, to drive that forward. We did it with tobacco. The numbers have come down astoundingly. You can do it with the new tobacco, obesity; you can do it with injury prevention. You absolutely can do that, particularly on the social marketing side by showing national leadership.

Senator Eggleton: Thank you very much for coming, Dr. Leitch.

Dr. Leitch: I will try not to be so passionate. I will contain myself.

enfant devrait faire l'objet d'un dépistage régulier comprenant entre autres un examen de la vue et un examen dentaire. On peut pratiquer de tels examens dans une polyclinique comme celles dont vous parlez. On outillerait ainsi les parents pour qu'ils puissent aider leurs enfants. Nous devons prévoir les ressources et les services pour y parvenir.

L'essentiel des leviers se trouvent dans les provinces. Toutefois, c'est le gouvernement fédéral qui a la responsabilité de la santé des Premières nations et des Inuits. Très peu de mécanismes font le lien. Il s'agit en premier lieu d'outiller les parents, c'est-à-dire de leur donner une liste de vérification pour qu'ils sachent ce qu'ils doivent faire pour leurs enfants. Ils sont nombreux à l'ignorer.

Le sénateur Eaton : Vous parliez du tabagisme et de la gestion des déchets, et je suis tout à fait d'accord. Pensez-vous que nous devrions lancer, par exemple, une campagne nationale sur le diabète, les soins oculaires ou la prévention? Les campagnes publicitaires nationales pour faire de la sensibilisation populaire sont-elles utiles?

Dre Leitch : Le gouvernement fédéral peut jouer un rôle très important dans le domaine de la prévention, mais je ne choisirais pas une maladie en particulier. Je ferais porter la campagne sur les facteurs causant l'obésité ou sur la prévention des blessures. Si on réussit à diminuer le nombre de blessures et que nous évitons ainsi à des enfants une visite à l'urgence, on fera des économies énormes. Il faut voir plus loin que le bout de son nez. Si, ce faisant, nous œuvrons à la prévention, nous ferons des économies et nous allègerons l'infrastructure sociale.

On peut faire des campagnes nationales. Le gouvernement fédéral peut jouer un rôle colossal à cet égard. Je l'ai dit à plusieurs endroits, lorsque j'ai rencontré des ministres et je vais le répéter ici : si vous saisissez l'occasion, vous pouvez avoir une influence énorme. Le pays va vous suivre. Vous l'avez fait pour le tabagisme et pour d'autres problèmes. Choisissez les grands dossiers où vous pouvez provoquer du changement et investissez dans ces dossiers pour que l'on fasse un bond en avant.

Aucun enfant ne devrait se retrouver à l'urgence au pays pour cause de noyade. Aucun enfant de cinq ans ne devrait se retrouver à l'urgence au pays pour y recevoir un diagnostic de diabète de type 2. Ce genre de choses ne devrait jamais se produire au pays.

Vous avez la possibilité, en tant qu'institution nationale, de lancer le pays sur la voie de tels progrès. Nous y sommes parvenus dans le cas du tabagisme. La diminution du nombre de fumeurs a été extraordinaire. Vous pouvez obtenir des résultats semblables avec l'équivalent actuel du tabac : l'obésité. Vous pouvez obtenir des résultats semblables dans la prévention des blessures. Vous pouvez tout à fait y arriver, en particulier si vous employez la mercatique sociale et si vous agissez en chefs de file nationaux.

Le sénateur Eggleton : Merci beaucoup d'être venue, docteure Leitch.

Dre Leitch : Je vais tâcher de ne pas me laisser emporter par la passion. Je vais me contenir.

Senator Eggleton: Congratulations on your excellent report. I hope you have had a chance to meet with the new minister of health, and I hope there is an interest in seeing your report fulfilled as much as possible.

My first question is whether you can give us any information about how well it is going through the system.

I will ask a couple of other questions. You speak passionately about our having the ability on a national level. It takes more than ability; it takes will and it takes working things out within a constitutional framework where there are shared responsibilities. Much of the responsibility for the delivery of these kinds of programs is at the provincial level. Some of it is carried out at the local level. Have you given any thought to how all of that might work better? National strategies in areas that involve the provinces require a fair bit of coordination. I am not for a moment suggesting we do not go that route; I am a fan of going that route.

My third question: in your key conclusions, you note that Canada ranks twenty-second when it comes to preventable childhood injuries, twenty-seventh in childhood obesity and twenty-first with children being included in mental health. These are OECD rankings. There is another one the committee dealt with recently: in a study of 14 OECD countries, in terms of early learning and childhood education, we came last.

I cannot recall all five recommendations, but in the specific areas you dealt with, you did not deal with early learning and childhood education. I noted that you did have very good comments in the appendix, where you said, for example, that if we want Canadian children to be successful and competitive later in life, we must do everything we can to stimulate their early development. You even pointed out the business case, as I might call it, that it has been repeatedly demonstrated that investments in early childhood education pay off in a better life and health outcomes later in life. Research estimates that every one dollar invested in childhood development is worth \$3 to \$18 later in life.

Why did you not get into this whole area of early learning and childhood education?

Dr. Leitch: To start with the third question, I had a very specific mandate letter that asked me to answer three questions. I probably stepped outside of my mandate letter more often than I probably should have, to begin with.

My mandate letter was very specific: to look at the programs of Health Canada and PHAC. Early childhood development and many of those other social determinants of health on the list were not addressed. They are addressed at HRSDC, INAC or Transport Canada, which is not to say they are not

Le sénateur Eggleton : Je vous félicite pour votre excellent rapport. J'espère que vous avez eu l'occasion de rencontrer la nouvelle ministre de la Santé et qu'elle s'est montrée désireuse de mettre en œuvre autant que possible les recommandations contenues dans votre rapport.

J'aimerais premièrement savoir si vous pouvez nous informer sur cette mise en œuvre.

J'aimerais aussi vous poser deux autres questions. Vous nous parlez avec passion de notre capacité d'agir à l'échelle nationale. Mais, il faut davantage qu'une capacité. Il faut une volonté et il faut respecter le cadre constitutionnel, où les responsabilités sont partagées. Les programmes de cette nature relèvent en grande partie des provinces. Ils sont parfois mis en œuvre à l'échelle locale. Avez-vous réfléchi aux améliorations possibles à cet égard? Les stratégies nationales dans des domaines qui relèvent des provinces nécessitent passablement de coordination. Je ne veux pas du tout laisser entendre que nous ne devrions pas emprunter cette voie. Au contraire, je suis tout à fait favorable à cette idée.

Ma troisième question porte sur vos constatations principales. Vous indiquez que le Canada occupe le vingt-deuxième rang pour les blessures évitables subies par les enfants, le vingt-septième rang pour l'obésité infantile et le vingt-et-unième rang pour les services de santé mentale fournis aux enfants. Ces classements sont issus de l'OCDE. Il y a un autre classement sur lequel le comité s'est penché récemment : dans une étude portant sur l'éducation préscolaire dans 14 pays de l'OCDE, le Canada s'est retrouvé au dernier rang.

Je ne peux pas me rappeler toutes les cinq recommandations, mais vous n'avez pas fait de recommandations concernant l'éducation préscolaire. En revanche, vous faites de très bonnes remarques dans l'annexe, où vous dites, par exemple, que si nous voulons que les enfants canadiens soient plus tard des adultes qui réussissent et qui sont capables de tirer leur épingle du jeu, nous devons tout faire pour stimuler leur développement en bas âge. Vous avez même signalé que la rentabilité des investissements en éducation préscolaire, si je puis m'exprimer ainsi, n'est plus à démontrer puisqu'ils rapportent d'importants dividendes plus tard au cours de l'existence, sur le plan de la qualité de vie et de la santé. Selon les études réalisées, on estime que chaque dollar investi dans le développement des enfants équivaut à un investissement de 3 à 18 dollars plus tard au cours de l'existence.

Pourquoi n'avez-vous pas abordé la question de l'éducation préscolaire?

Dre Leitch : Permettez-moi de commencer par la troisième question. On m'a confié un mandat très précis, soit de répondre à trois questions. Je suis probablement sortie du cadre de mon mandat plus souvent que je ne l'aurais dû.

Mon mandat était très précis : examiner les programmes de Santé Canada et de l'Agence de la santé publique du Canada. Le développement des jeunes enfants et nombre d'autres déterminants sociaux de la santé ne sont pas visés par ces programmes. Ils relèvent du ministère des Ressources humaines et

exceptionally important. For an orthopaedic surgeon, it was exceptionally educational to learn about these things, and it has definitely changed my practice.

The scope of the report was based on the mandate letter I was given. It is not that early learning and childhood education are not important; I think they are exceptionally important and they should be taken in totality when they are dealt with, but the report speaks to the letter that I was given.

I think there would be huge value in something similar to this being done, looking at the 12 social determinants of health, how they can affect children and youth across the country and how they can best be integrated appropriately to address broader health needs, particularly on the preventive side.

With regard to the system here in Ottawa, you people are probably more attuned to how it functions than I am. I was independent council, and how this world works is not my day job, albeit it was very educational.

Both the Deputy Minister of Public Health, David Butler-Jones, and the Deputy Minister of Health Canada, Morris Rosenberg, were exceptionally helpful in ensuring the report came to fruition, and their staff contributed a great deal to it. I continue to work with them.

I have been pleasantly surprised that this report has not gone to the shelf. I speak publicly on it at least once or twice a week. I know the Deputy Minister of Public Health is taking it seriously and is integrating many ideas from it into his own world, as is Morris Rosenberg at Health Canada. It was part of the strategic review process in a very straightforward manner, not that I know everything that happens with strategic review, not being from here, but it has been taken seriously, which is constructive. I have heard that not just from them, but also from the programs on the ground where they have been asked to change their practice to address the three big issues that Canadian parents came forward with.

With regard to implementation of national strategies, my third great learning was about federal-provincial-territorial relations on this. I think everyone in the country understands that we need to move the dial on these things. There are different ways of reaching the goal but, ultimately, I believe everyone thinks that we need to collaborate to make it happen.

One question I was asked was whether there should be a continuous voice in the Government of Canada on these issues. I talk about having an assistant deputy minister at Health Canada. Having spent the last year dealing with stakeholders in the space — and not just my academic colleagues but large service organizations such as the YMCA, which sees over a million children through its doors each year, the United Way and others

du Développement des compétences, du ministère des Affaires indiennes ou du ministère des Transports, ce qui ne veut pas dire qu'ils ne sont pas d'une importance capitale. À titre de chirurgienne orthopédique, j'ai énormément appris sur le sujet, et ma pratique en a été certainement modifiée.

J'ai produit un rapport correspondant au mandat qui m'a été confié. Ce n'est pas à dire que l'éducation préscolaire n'est pas importante. C'est une question d'une importance exceptionnelle, qui mérite d'être étudiée de façon exhaustive, mais le rapport que j'ai produit est le résultat du mandat qui m'a été confié.

Je crois qu'on aurait grandement intérêt à accomplir un travail semblable au mien sur les 12 déterminants sociaux de la santé, pour cerner leur effet sur les enfants et les adolescents du pays et pour déterminer comment on devrait s'y prendre pour répondre plus largement aux besoins en matière de santé, particulièrement en ce qui concerne la prévention.

Pour ce qui est du système relevant d'Ottawa, vous savez probablement mieux que moi comment il fonctionne. Je suis une conseillère indépendante. Le fonctionnement de cet univers ne fait pas partie de mes compétences, même s'il est très enrichissant pour moi d'en apprendre à ce sujet.

L'administrateur en chef de la santé publique, David Butler-Jones, et le sous-ministre de Santé Canada, Morris Rosenberg, m'ont apporté une collaboration exceptionnelle pour que le rapport puisse être produit. Leur personnel y a grandement contribué. Je continue de collaborer avec eux.

J'ai été agréablement surprise de voir que ce rapport n'a pas été simplement rangé sur une tablette. Je prends la parole en public au moins une ou deux fois par semaine à ce sujet. Je sais que l'administrateur en chef de la santé publique prend le rapport très au sérieux et qu'il y puise beaucoup d'idées pour les intégrer dans l'univers où il travaille, tout comme le fait également Morris Rosenberg, à Santé Canada. Le rapport a fait très directement partie d'un examen stratégique. Ne connaissant pas les rouages de l'État fédéral, je suis loin de tout savoir sur les examens stratégiques, mais je sais que le rapport a été pris au sérieux, ce qui est constructif. Ce ne sont pas seulement les dirigeants qui me l'ont dit, mais aussi les responsables des programmes sur le terrain, qui se sont fait dire de changer leurs pratiques pour s'attaquer aux trois grands problèmes que les parents canadiens ont soulevés.

En ce qui a trait à la mise en œuvre de stratégies nationales, j'en ai beaucoup appris sur un troisième sujet, soit les relations fédérales-provinciales-territoriales. Je pense que tout le monde au pays comprend que nous devons faire un bond en avant sur ces questions. Il y a diverses manières d'atteindre l'objectif, mais, en fin de compte, je crois que tout le monde pense que nous devons collaborer pour y parvenir.

Entre autres questions, on m'a demandé s'il devrait y avoir un porte-parole au gouvernement du Canada s'occupant en permanence de ces questions, c'est-à-dire un sous-ministre adjoint qui en serait chargé à Santé Canada. Après avoir passé la dernière année à m'intéresser aux acteurs du domaine, c'est-à-dire pas seulement mes collègues du milieu universitaire, mais également les grands organismes de services comme l'Alliance

— I believe there needs to be a voice for children and child and youth health in the country. However, probably the best way to interact with the provinces and territories and with other community service groups is to have that group outside of government, to have it function essentially as a think tank, a foundation outside of government or at arm's length from government so that the provinces more freely interact with it and it acts more as an independent voice, giving advice and good ideas in public policy development so that there can be a more collaborative environment than if it were housed in the Province of Ontario or within the Government of Canada.

My efforts had been focused on developing that entity as a non-governmental organization to represent child and youth health and the new ideas.

Senator Eggleton: You call it the national office for child and youth.

Dr. Leitch: That is how I outlined it in the text.

Senator Eggleton: Did you consider the possibility of a cabinet-level position, such as a secretary of state, which is a junior cabinet position? We have one for seniors; why would we not have one for children and youth?

Dr. Leitch: There were many options on the table. Ontario, for example, has is a minister responsible for children's services, the Honourable Deb Matthews. Different than in my own report, I have come to the conclusion that having an entity outside of government that acts as an independent voice on child and youth health and that interacts with all governments as well as all NGOs and others in the space could be far more powerful as an independent body than having something situated within the government.

Senator Eggleton: Would you see the mandate for this independent body coming from the federal government?

Dr. Leitch: Ideally, it would come from a national body, yes, and it would meet the criteria I outlined in the report of doing policy development and ideas development, ensuring there is a collaborative environment and a research evidence base for that. Ideally this body would be supported by the federal government but also have the opportunity for the provinces to more freely interact with it.

Senator Eggleton: Thank you. Keep pushing.

Dr. Leitch: I am working on it. Would you like to join the cause?

universelle des unions chrétiennes de jeunes gens, qui accueille plus d'un million d'enfants chaque année dans ses programmes, comme Centraide et comme d'autres organismes, j'arrive à la conclusion qu'il doit y avoir un porte-parole au pays chargé de la santé des enfants et des adolescents. Cependant, pour interagir de manière optimale avec les provinces, les territoires et les groupes œuvrant dans le domaine des services communautaires, il faut mieux que ce porte-parole soit indépendant du gouvernement et qu'il fonctionne essentiellement sur le modèle des groupes de réflexion. Ce serait une fondation possédant l'indépendance voulue par rapport au gouvernement, de telle sorte que les provinces puissent interagir librement avec elle. Il s'agirait ainsi d'un porte-parole indépendant qui distribuerait les conseils et les bonnes idées pour l'élaboration des politiques publiques, de manière à créer un environnement plus propice à la collaboration que si les conseils et les idées venaient d'un organe de la province de l'Ontario ou du gouvernement du Canada.

Mes efforts ont visé la mise sur pied d'un organisme non gouvernemental chargé d'agir comme porte-parole en matière de santé des enfants et des adolescents et de formuler des idées nouvelles.

Le sénateur Eggleton : Vous appelez cet organisme le bureau national de la santé des enfants.

Dre Leitch : C'est le nom que je lui donne dans le texte.

Le sénateur Eggleton : Avez-vous envisagé la possibilité de nommer une personne qui siègerait au Cabinet, comme un ministre d'État, soit un ministre de second rang? Il y a un ministre qui est chargé des aînés, pourquoi n'y en aurait-il pas un pour les enfants et les adolescents?

Dre Leitch : De nombreuses options sont à l'étude. En Ontario, par exemple, il y a une ministre des Services à l'enfance, Mme Deb Matthews. C'est différent de ce que je préconise dans mon rapport, où je conclus qu'il vaut mieux créer une entité indépendante du gouvernement pouvant agir comme porte-parole indépendant en ce qui a trait à la santé des enfants et des adolescents et pouvant interagir avec tous les gouvernements ainsi qu'avec les ONG et les autres acteurs de cet univers. Grâce à son indépendance, un tel organisme serait beaucoup plus puissant que s'il se trouvait rattaché au gouvernement.

Le sénateur Eggleton : Le mandat de cet organisme indépendant lui serait-il confié par le gouvernement fédéral?

Dre Leitch : Idéalement, le mandat lui serait confié par une institution nationale. Il répondrait aux critères que j'ai définis dans le rapport et qui exigent qu'il s'occupe d'élaborer des politiques et de trouver des idées, tout en veillant à susciter un climat de collaboration et en s'assurant qu'il dispose de données issues de la recherche. Idéalement, cet organisme serait financé par le gouvernement fédéral, mais les provinces pourraient interagir librement avec lui.

Le sénateur Eggleton : Merci. Continuez votre travail de persuasion.

Dre Leitch : Je m'y emploie. Voudriez-vous épouser cette cause?

Senator Eggleton: Absolutely. I am with you.

Dr. Leitch: I will give you my business card at the end.

Senator Fairbairn: Thank you very much. Listening to you raises all sorts of memories, although not of myself.

Dr. Leitch: I hope good ones.

Senator Fairbairn: I think you mentioned it early on, but with respect to the advancement of children and the whole question of literacy and learning, not just that it is out there for themselves, but within families which themselves may not be high on that list, how much of a degree is that in elevating the opportunity for the earliest childhood chances, that they will be able to climb up that ladder and be able to reach out with others, and without that kind of centrepiece how hard is that as far as trying to build them for a future?

Dr. Leitch: The issues of early childhood education and literacy were outside the scope of the mandate for my report, albeit I heard a great deal about it.

As I said in the appendix of the report, which I thought was important, having a literate society is exceptionally important. It does move the bar. We may have all these social marketing tools, but having people being able to internalize them and, because of that, change their behaviour, is exceptionally important.

I am a product of a wonderful Canadian education. I spent half of my life in post-secondary education, let alone in primary school. I think it is exceptionally important that we as Canadians provide parents and children the opportunity to be able to function well within society by being able to read, write and participate.

Senator Fairbairn: Even though we are seen as a very proud and learned country, the statistics in this country on the number of adult Canadians with difficulty with literacy and learning seem to go on and on.

Dr. Leitch: One of the great programs the federal government participates in is the Aboriginal Head Start Program, which is tailored for children.

Senator Fairbairn: That is terrific.

Dr. Leitch: It is a comprehensive program dealing with many of the social determinants of health, in addition to those that are specifically health care oriented.

Senator Fairbairn: They have worked hard at it.

Le sénateur Eggleton : Tout à fait. Vous pouvez compter sur moi.

Dre Leitch : Je vous laisserai ma carte de visite à la fin.

Le sénateur Fairbairn : Merci beaucoup. À vous écouter, toutes sortes de souvenirs me reviennent à l'esprit, mais ce ne sont pas des souvenirs personnels.

Dre Leitch : J'espère qu'il s'agit de bons souvenirs.

Le sénateur Fairbairn : Je pense que vous en avez parlé tout à l'heure. Ce sont des souvenirs qui concernent le développement des enfants, leur alphabétisation et leur apprentissage. Il ne s'agit pas de considérer les enfants isolément, mais en tant que membres de familles qui se trouvent elles-mêmes à un échelon peu élevé sur ce plan. En offrant aux enfants de meilleures chances lorsqu'ils sont encore tout jeunes, de combien améliore-t-on leurs chances de grimper les échelons pour se retrouver au même niveau que les autres? Sans cette pièce maîtresse, dans quelle mesure est-il difficile de les aider à se développer pour qu'ils aient un avenir prometteur?

Dre Leitch : Les questions de l'éducation préscolaire et de l'alphabétisation n'étaient pas comprises dans le mandat qu'on m'a confié, en vue de la rédaction de mon rapport, même si j'ai beaucoup entendu parler de ces questions.

Comme je l'ai dit dans l'annexe du rapport, qui m'apparaît importante, il est crucial que la société soit instruite. On part ainsi d'un niveau plus élevé. On peut bien se doter de tous les instruments de mercatique sociale qu'on voudra, il reste qu'il est d'une importance cruciale que les gens soient capables de bien intégrer les connaissances que l'on diffuse, ce qui les amène à changer leur comportement.

Je suis moi-même le produit d'un merveilleux système d'éducation canadien. J'ai passé la moitié de ma vie à faire des études postsecondaires, sans compter l'école primaire. Je pense qu'il est d'une importance capitale qu'en tant que Canadiens, nous donnions aux parents et aux enfants les outils nécessaires pour pouvoir bien fonctionner dans la société, c'est-à-dire la capacité de lire, d'écrire et de participer à la vie de la société.

Le sénateur Fairbairn : Même si on nous voit comme un pays de gens fiers et instruits, les statistiques sur le nombre d'adultes canadiens qui ont peine à lire et à écrire et qui manquent d'instruction ne semblent jamais montrer une amélioration de la situation.

Dre Leitch : L'un des programmes formidables auxquels participe le gouvernement fédéral est le programme Bon départ pour les Autochtones, qui est conçu sur mesure pour les enfants.

Le sénateur Fairbairn : C'est formidable.

Dre Leitch : C'est un programme exhaustif qui vise de nombreux déterminants sociaux de la santé, en plus des déterminants qui sont liés aux soins de santé.

Le sénateur Fairbairn : Ce programme est le fruit de beaucoup de travail.

Dr. Leitch: They have done well. It is evidence-based. We have seen evidence of the dial being moved because of it, such as higher graduation rates. I have encouraged the federal government to invest in it in an effort to increase the capabilities of our Aboriginal population across the country. The federal government is involved in some programs that are definitely doing a very good job of trying to move that bar in literacy.

Senator Cook: I would like to look at the most vulnerable children in our society, and they are the children living in poverty. I look at obesity and the availability of food and what those children are provided with. Do you have any answers for that?

Children spend most of their day in the school setting. In my province, there are wonderful breakfast programs where they get proper, nutritious food. Then there is the cafeteria. I think school cafeterias are the worst perpetrators of obesity for children. I know you cannot legislate common sense, but is there any way that can be addressed? How much can you impose in a democracy?

Dr. Leitch: I cannot say I know the three ticket items you should implement in your province to make the dial change. However, I do believe that if we bring together the experts — not just in the academic world but also NGOs, industry and others — in a centre of excellence on childhood obesity to determine what those best practices are and how they can be implemented, I believe we can change the dial.

I think creating the right incentives and behavioural change among parents, as well as among children, is important. The children's fitness tax credit was implemented in first in Nova Scotia and then by the federal government as a tool to motivate individuals to be more involved.

Is there something similar we could implement that would draw behavioural change on the nutrition side of that equation, as well as on the activity side? I do not know whether we have the answer to that. Part of that may be incentives for industry for changing portion sizes and ensuring labelling is better so that people are better educated. These are things I outlined in the report.

Senator Cook: The industry loves to make cereals laced with sugar.

Dr. Leitch: I agree.

Senator Cook: Is there any way, given that we live in a democracy, we can dictate to industry?

Dre Leitch : Ils ont obtenu de bons résultats. C'est un programme qui repose sur les données de la recherche. Il y a désormais des données montrant qu'il a permis de faire un bond en avant. J'ai encouragé le gouvernement fédéral à investir dans ce programme pour accroître les capacités de la population autochtone partout au pays. Le gouvernement fédéral participe à des programmes qui sont certainement très efficaces pour hausser le degré d'alphabétisation de la population.

Le sénateur Cook : J'aimerais que nous discussions des enfants les plus vulnérables de la société, c'est-à-dire les enfants vivant dans la pauvreté. Il faut voir que les problèmes d'obésité sont liés à la disponibilité de la nourriture et à ce que ces enfants ont à manger. Avez-vous des réponses à ce sujet?

Les enfants passent la plus grande partie de leur journée en milieu scolaire. Dans ma province, il y a de merveilleux programmes de déjeuner grâce auxquels les enfants consomment des aliments nutritifs. Puis, il y a la cafétéria. Je pense que les cafétérias scolaires sont les plus coupables de tous en ce qui concerne l'obésité des enfants. Je sais que vous ne pouvez pas légiférer pour imposer le bon sens, mais y aurait-il un moyen de résoudre ce problème? Jusqu'où peut-on aller quand vient le temps d'imposer des règles dans une démocratie?

Dre Leitch : Je ne vous dirai pas que je connais la recette magique à suivre dans votre province pour qu'on y fasse un bond en avant. Cependant, je crois que si nous réunissions, dans un centre d'excellence sur l'obésité infantile, des experts non seulement en provenance du milieu universitaire, mais également en provenance des ONG, de l'industrie et d'autres milieux, en leur confiant la tâche de cerner les pratiques exemplaires et de trouver des moyens de les mettre en œuvre, ils nous montreront la voie à suivre pour faire un bond en avant.

Je pense qu'il est important d'offrir les incitatifs nécessaires pour susciter des changements de comportement parmi les parents et les enfants. Le crédit d'impôt pour la condition physique des enfants a été adopté en Nouvelle-Écosse d'abord, et ensuite par le gouvernement fédéral, comme outil de motivation pour favoriser la pratique de l'activité physique.

Y a-t-il une mesure semblable que nous pourrions mettre en œuvre pour provoquer des changements de comportement relativement à l'alimentation, de même que des changements relatifs aux habitudes d'activité physique? Je ne sais pas si nous avons la réponse à cette question. On pourrait entre autres inciter l'industrie à réduire les portions et à améliorer l'étiquetage pour mieux éduquer les gens. Ce sont des mesures proposées dans le rapport.

Le sénateur Cook : L'industrie adore mettre beaucoup de sucre dans les céréales.

Dre Leitch : Je suis d'accord.

Le sénateur Cook : Compte tenu du fait que nous vivons dans une démocratie, y aurait-il moyen de dicter des règles à l'industrie?

Dr. Leitch: I give some industry leaders some credit. Through the course of the report, I had the opportunity to deal with one large industry leader that produces a lot of soda pop. They came to me and said we want to be somewhat socially responsible. I said then you actually have to prove it.

We have this problem on the obesity side of the equation, but one thing we do not have for children is after-school programs. After-school programs address a bunch of issues, not just the obesity issue. They ensure kids are safe and have a place to go in that witching hour between 3 p.m. and 6 p.m.

I challenged them: Why not fund after-school programs and have an incentive there for children? They are one of the companies involved with the torch for the Olympics. The children who improve the most and participate the most, not the fastest runners in the class but the children that who improve the most, would get to carry the torch.

To their credit, they have stepped up to the plate. They have invested \$10 million; they are running after-school programs in 1,000 places across the country and the kids who improve the most will carry the torch.

It is not ideal. We have not eliminated soda pop, but we have created a degree of social responsibility for dealing with children, so it drives some change in what they do.

The other part is that they are interacting with children more, particularly working with ParticipACTION, so they are hearing more about how to have some behavioural change. That is exceptionally important.

Will we have one big leap? I do not think so, but I think baby steps like that will be constructive and useful. We need to identify more of them so that we can drive behavioural change.

Senator Cook: The stark reality in today's world is that mom or dad drops the kids off at a preschool or daycare centre at seven or eight o'clock in the morning and picks them up at the same time at night. All the children's waking hours are spent someplace else. Is there an opportunity to get into the daycare systems in this province and make it part of their licensing? Should healthy foods be made mandatory?

Dr. Leitch: I do not think it is just daycare. This spans children outside the 0 to 5 year-old age group. This also affects kids up until they are 16. That witching hour you are talking about, not just the early time but the witching hour between 3 p.m. and 6 p.m., is exceptionally important.

Dre Leitch : Les dirigeants de l'industrie méritent qu'on souligne leurs efforts. Au cours de la préparation du rapport, j'ai eu l'occasion de discuter avec les représentants d'un grand producteur de boissons gazeuses, qui est un joueur important de l'industrie alimentaire. Ils sont venus me dire qu'ils voulaient agir de manière socialement responsable. Je leur ai répliqué qu'ils devaient en faire la preuve.

Le problème de l'obésité est une équation dont l'alimentation est une variable, mais nous n'avons pas de programmes parascolaires, qui seraient utiles pour lutter contre beaucoup de problèmes, et non uniquement le problème de l'obésité. Grâce à de tels programmes, les élèves peuvent avoir un endroit où aller et être entre bonnes mains pendant la période magique entre 15 et 18 heures.

J'ai mis le producteurs de boissons gazeuses au défi : pourquoi ne pas financer des programmes parascolaires et trouver des moyens d'y attirer les enfants? C'est l'un des commanditaires du relais de la flamme olympique. Les enfants qui s'améliorent le plus et qui participent le plus, et non les coureurs les plus rapides de leur classe, auraient le privilège de porter la flamme.

Rendons à César ce qui est à César : le producteur de boissons gazeuses a relevé le défi. Il a investi 10 millions de dollars dans des programmes parascolaires à 1 000 endroits au pays, et les enfants qui vont s'améliorer le plus vont porter la flamme.

Ce n'est pas l'idéal. Nous n'avons pas éliminé les boissons gazeuses, mais nous avons suscité une certaine prise de conscience sociale concernant les enfants, qui est susceptible d'entraîner des changements de comportement.

En outre, on interagit davantage avec les enfants, notamment dans le cadre du programme ParticipACTION, ce qui permet d'entendre parler plus souvent des moyens de susciter des changements de comportement. C'est très important.

Allons-nous faire un saut quantique? Je ne pense pas, mais je pense que les petits pas sont constructifs et utiles. Nous devons trouver davantage de moyens de faire des petits pas, de manière à ce qu'on obtienne des changements de comportement.

Le sénateur Cook : Dans la dure réalité du monde d'aujourd'hui, les parents emmènent leur enfant au service de garde dès sept ou huit heures le matin et les y reprennent à la même heure le soir. Toutes les heures d'éveil des enfants sont passées ailleurs que chez eux. Serait-il possible de fixer des conditions d'obtention du permis de garderie dans cette province? Devrait-il être obligatoire pour les garderies de ne servir que des aliments sains aux enfants?

Dre Leitch : Je ne pense pas que l'enjeu se limite aux garderies. Les enfants de plus de 5 ans sont également concernés. Les jeunes sont concernés jusqu'à 16 ans. Ce ne sont pas seulement les premières heures de la journée qui sont importantes. Cette période magique dont vous parlez, c'est-à-dire entre 15 et 18 heures, a une importance cruciale.

Eighty per cent of Canadian parents now work. Parents are wondering where their children are during that time. They are not that productive at work at that time because they are checking their watch to see when they have to pick up their children. Also, who knows where their children are.

If we create after-school programming that effectively deals with ensuring children are safe, that they are eating well, that they have activities to do that their parents are confident in, I think that will move the bar a long way in this country. That is not just about the 0 to 5 year-olds, but up to 16 year-olds as well — particularly the 6 to 12 year-old age group.

Senator Cook: I come from the province of Newfoundland where there is a fair sprinkling of after-school programs, but they cost money.

Dr. Leitch: I agree. There are many incentives that both the provincial and federal governments have invested in for the early years. I give them credit. There have been a variety of facets; the provincial governments have done some things and I know the federal government has done others. I am not an expert in that.

I would encourage both the provincial and the federal level to look at how to address that after-school programming time frame from 3 p.m. to 6 p.m. It may require asking the provinces for structural change, to change the time kids go to school; maybe they should go to school from 10 a.m. to 6 p.m.

Senator Cook: But mom goes to work at 9 a.m.

Dr. Leitch: I just throw that out there. It could be we are dealing with ensuring we provide an incentive for parents to utilize an after-school program. I am sure there are lots of mechanisms, machinery-of-government issues that I know nothing about, that definitely could incent the use of those. I agree with you completely that that 3 p.m. to 6 p.m. witching hour needs to be addressed, provincially and federally.

Senator Cook: Regarding mental health services, is there no screening for children age 3 when they are doing their preschool? Are mental health services a part of the screening for children before they enter school?

Dr. Leitch: Not in all provinces and not in all locations in all provinces.

Senator Cook: Would you advocate that?

Dr. Leitch: It is part of the report card that kids should go through to make sure they are reaching certain developmental levels so that we know early if they are falling off the dial and we can intervene sooner.

Quatre-vingts pour cent des parents canadiens sont sur le marché du travail de nos jours. Les parents se demandent où sont leurs enfants pendant cette période. Ils ne sont pas tellement productifs au travail à ces heures-là parce qu'ils passent leur temps à regarder leur montre et à se demander s'il est l'heure de passer prendre leurs enfants ou à se demander ce que font leurs enfants.

Si nous créons des programmes parascolaires efficaces pour nous assurer que les enfants sont entre bonnes mains, qu'ils s'alimentent bien et qu'ils ont des activités à faire en lesquelles les parents ont confiance, je pense que le pays fera un grand pas en avant. Il ne s'agit pas seulement des enfants de 5 ans et moins, mais également des jeunes de 16 ans et moins, en particulier ceux qui appartiennent au groupe des 6 à 12 ans.

Le sénateur Cook : Je viens de la province de Terre-Neuve, où existe une bonne quantité de programmes parascolaires. Mais, ces programmes coûtent de l'argent.

Dre Leitch : Je suis d'accord. Les gouvernements fédéral et provinciaux ont investi dans de nombreux incitatifs pour les jeunes enfants. Je reconnais qu'ils ont fait du bon travail à cet égard. Il y a divers volets à ces mesures. Les provinces ont mis l'accent sur certaines choses, tandis que le gouvernement fédéral a mis l'accent ailleurs. Je ne suis pas une experte dans ce domaine.

Je conseillerais aux provinces et au gouvernement fédéral de se pencher sur la question des programmes parascolaire à offrir entre 15 h et 18 h. Il est possible que les provinces soient obligées de faire des changements structurels, c'est-à-dire de changer la durée de la journée scolaire. Les jeunes devraient peut-être aller à l'école de 10 à 18 heures.

Le sénateur Cook : Mais, la maman doit être au travail à 9 heures.

Dre Leitch : Je lance cette idée simplement comme ça. Il s'agirait peut-être d'inciter les parents à utiliser les programmes parascolaires. Je suis certaine qu'il y a beaucoup de mécanismes et de subtilités dans la mécanique dans l'administration publique dont je ne suis pas consciente et qui pourraient servir à inciter les parents à avoir recours à de tels programmes. Je suis absolument d'accord avec vous pour dire que, tant à l'échelon provincial qu'à l'échelon fédéral, il faut s'attaquer au problème de la période magique entre 15 et 18 heures.

Le sénateur Cook : En ce qui concerne les services de santé mentale, n'y a-t-il pas du dépistage qui se fait parmi les enfants de 3 ans qui vont à la prématernelle? Les services de santé mentale font-ils partie du dépistage effectué parmi les enfants d'âge préscolaire?

Dre Leitch : Pas dans toutes les provinces, et pas à tous les endroits dans les provinces.

Le sénateur Cook : Êtes-vous favorable à ce dépistage?

Dre Leitch : Le dépistage fait partie du bilan qu'il faudrait produire régulièrement pour chaque enfant, de manière à s'assurer qu'il atteigne normalement les divers stades de développement et de manière à savoir le plus tôt possible si l'enfant accuse du retard et s'il y a lieu d'intervenir.

Senator Cook: I apologize I did not get to read your book. There was so much else coming at me. However, I will; you have sparked my interest.

I have one last personal question. We have three little kids; they are three, four and a half, and six and a half. They travel occasionally on a holiday. Invariably, we have to book the car seats and the booster seats. No matter how many contracts we sign with rental companies, we have yet to get the seats that we bought and paid for to put the children in to keep them safe. What can you do about the industry? My daughter would love to know that one. The last occasion was a couple of months ago.

Dr. Leitch: The number of parents who showed up to talk to me about how they did not know how to install their booster seat was phenomenal in the last year. I feel like I have become an expert in this area.

I was at a conference in June last year, called Auto21, with the 131 auto manufacturers in the country. They asked me to present regarding childhood injuries and what they could do.

I presented to them a whole series of slides and showed them in gory detail what I take care of when kids are ejected from motor vehicles. You could see they were stunned in the audience, thinking good grief, how can I have an impact on this? They can have a substantial impact by doing either of two things. They could build into their vehicles a booster seat. My Volvo has a booster seat built into it. I do not have to buy a booster seat. I just have to flip up the lid and set the kid in the booster seat. It is safe and meets requirements. Other industry leaders could do that.

The second thing is they could make booster seats easy to put in, such as by having a tiny sensor that changes the colour of the light so you know it is inserted properly. These are small things engineers could do that would make a huge difference for parents in either having a booster seat or inserting one.

The other thing we need in this country is booster seat legislation in every province. Currently we do not have that. It astounds me that only 28 per cent of the Canadian parents whose child should be in a booster seat actually have one and utilize it in their car. That is a result of not having legislation across the country that is equivalent in all provinces, and it is actually part of enforcement. There are definitely things on the legislative-regulatory side, both provincially and federally, as well as on the manufacturing-industry side, that we could change that would

Le sénateur Cook : Je regrette de ne pas avoir lu votre livre. J'étais littéralement débordé. Cependant, je vais finir par m'y mettre. Vous avez piqué ma curiosité.

J'ai une dernière question d'ordre personnel à vous poser. Nous avons trois petits enfants, âgés de trois ans, quatre ans et demi et six ans et demi. Pendant les vacances, nous partons en voyage avec eux à l'occasion. Nous devons alors réserver les sièges d'auto et les sièges d'appoint. Peu importe les contrats que nous signons avec les entreprises de location, nous n'obtenons jamais les sièges dont nous avons payé la location pour y asseoir les enfants en toute sécurité. Que pourrait-on faire au sujet de l'industrie? Ma fille aimerait beaucoup avoir la réponse à cette question. La dernière occasion s'est présentée il y a environ deux mois.

Dre Leitch : Un nombre astronomique de parents sont venus me dire qu'ils ne savaient pas comment installer le siège d'appoint de leur voiture. J'ai l'impression d'être devenue une experte dans ce domaine.

J'ai assisté en juin dernier à un congrès qui s'appelait Auto21, auquel participaient les 131 constructeurs d'automobiles du pays. Ils m'ont demandé de prononcer une conférence sur les blessures subies par les enfants et sur les mesures qu'ils pouvaient prendre à cet égard.

Je leur ai présenté toute une série de diapositives pour leur montrer en détail dans quel état les enfants m'arrivent lorsqu'ils sont éjectés hors d'un véhicule automobile. La salle a été visiblement assommée par mon exposé. Les gens se demandaient ce qu'ils pouvaient faire pour empêcher ce genre de blessures. Ils ont en fait le choix entre deux solutions pour réduire le risque substantiellement. Ils peuvent construire des véhicules avec siège d'appoint intégré, comme dans ma Volvo. Je n'ai pas besoin d'acheter un siège d'appoint. Je n'ai qu'à soulever un couvercle, puis je peux installer l'enfant dans un siège d'appoint qui est sécuritaire et qui répond aux exigences. D'autres chefs de file de l'industrie pourraient adopter cette solution.

La deuxième solution consiste à fabriquer des sièges d'appoint faciles à installer, qui seraient accompagnés de minuscules senseurs ayant pour effet de changer la couleur d'un voyant afin d'indiquer que le siège est bien installé. Ce sont des petits détails que les ingénieurs pourraient intégrer à leurs plans et qui permettraient aux parents soit d'utiliser un siège d'appoint intégré soit d'en ajouter un de manière optimale.

Il nous faut également des dispositions législatives sur les sièges d'appoint dans chaque province du pays. Actuellement, il n'y en a aucune. Je suis renversé de savoir que seulement 28 p. 100 des parents canadiens dont les enfants auraient besoin d'un siège d'appoint dans leur voiture en utilisent effectivement un. C'est le résultat de l'absence, dans l'ensemble du pays, de dispositions législatives équivalentes d'une province à l'autre que l'on serait en mesure de faire respecter. Il y a certainement des mesures à prendre sur le plan législatif et réglementaire, à l'échelon

have a huge impact on ensuring that children are safe in vehicles. That is among the leaders of preventable injuries for kids.

Senator Cook: Something needs to be done in that area. Industry has some responsibility for providing some of those initiatives.

Dr. Leitch: For sure.

Senator Cook: That evening, I knew someone was going to jail. I did not know it was going to be my daughter or the fellow who came with inadequate equipment. We sat in an airport for four hours while he went and bought three car seats. There are horror stories out there for this kind of thing. Surely there is some way we can address it. In my province there is legislation. I think national standards might be the norm. Car manufacturers are having problems now. Maybe when they turn around they will build adequate seats.

The Chair: Just before we wrap up, I want to thank you for coming before us. I have had an opportunity to talk to you privately about this two or three times. It is wonderful to have you on the record.

I was intrigued in previous conversations and today with how you addressed organization to try to get buy-in from the various constituents necessary to move the agenda. The thing you shied away from was a silo by appointing some ministry or formal appointment or arm of government. Instead you moved to the side of government, which helps people to become more comfortable to participate.

In the determinants of health, which are much broader than your mandate was, we struggled with this also. For a while, we tried to envision where a minister of human development would fit federally or provincially. We discovered that it would not fit because it was too narrow, even though human development is the core of what we are talking about in population health. We have settled pretty well, because our report is in the process of being written now, unless something very unusual happens, on an all-of-government approach; in other words, cabinet committee, federally, provincially, in the cities, community organizations that fit in this kind of thing. This organization has worked in the countries that have moved the agenda on population health.

I just wanted to hear your comment on that and get it on the record.

provincial, à l'échelon fédéral et de la part des constructeurs d'automobiles. Ces changements auraient un effet énorme pour assurer la sécurité des enfants dans les véhicules. Ils se trouvent parmi les mesures qui seraient les plus efficaces pour prévenir les blessures subies par les enfants.

Le sénateur Cook : Il faut faire quelque chose dans ce domaine. L'industrie a la responsabilité de prendre une partie de ces mesures.

Dre Leitch : Certainement.

Le sénateur Cook : Ce soir-là. Je savais que quelqu'un irait en prison. Je ne savais pas si ce serait ma fille ou le type qui nous avait fourni de l'équipement inadéquat. Nous sommes demeurés à l'aéroport pendant quatre heures en attendant qu'il revienne avec les trois sièges d'auto qu'il était parti acheter. Il y a des gens qui vivent des histoires d'horreurs autour relativement à cette question. Il y a certainement un moyen de résoudre le problème. Dans ma province, il y a une loi. Je pense qu'on pourrait établir des normes nationales. Les constructeurs d'automobiles ont des problèmes actuellement. Peut-être qu'une fois qu'ils se seront rétablis, ils muniront leurs automobiles de sièges adéquats.

Le président : Juste avant de terminer, je voudrais vous remercier d'être venue témoigner devant nous. J'ai eu l'occasion de m'entretenir avec vous deux ou trois fois en privé sur cette question. C'est merveilleux d'avoir pu recueillir votre témoignage officiel.

J'ai été intrigué au cours de nos conversations antérieures et de votre témoignage d'aujourd'hui, lorsque vous nous avez raconté comment vous vous y êtes prise pour obtenir l'adhésion des divers acteurs nécessaires et pour faire avancer les choses. Vous vous êtes dissociée de l'idée de constituer un vase clos en nommant une personne à un poste de ministre ou à un autre poste au sein du gouvernement. Vous nous avez plutôt proposé de constituer un organisme indépendant du gouvernement, pour que les gens se sentent plus à l'aise dans leur participation à ce dossier.

Nous avons eu des difficultés avec cette question également dans le dossier des autres déterminants de la santé, qui sont beaucoup plus nombreux que ceux qui étaient inclus dans votre mandat. Pendant un certain temps, nous avons essayé de définir le rôle d'un ministre du développement humain à l'échelon fédéral ou provincial. Nous nous sommes aperçus qu'un tel rôle serait trop pointu, même si le développement humain se trouve au cœur de la question de la santé des populations. Nous avons fait notre nid, et notre rapport est déjà en cours de rédaction. Nous n'en changerons pas la substance à moins que se produise quelque chose de très inhabituel. Le rapport proposera une nouvelle approche réunissant l'ensemble des pouvoirs publics, autrement dit un comité du Cabinet, l'échelon fédéral, l'échelon provincial, les villes et les organismes communautaires qui sont des acteurs dans ce dossier. L'organisation que nous proposons a eu des effets salutaires dans les pays qui ont voulu intervenir pour améliorer la santé des populations.

J'ai simplement voulu entendre vos commentaires à ce sujet et les consigner officiellement.

Dr. Leitch: I am very much in favour of the whole-of-government approach. The place in the country that has had the most effective impact on moving the dial with respect to children has been the one province that has done that, which is Manitoba. In Manitoba, they have taken a whole-of-government approach to dealing with child health. All deputy ministers and all ministers are at some point in time in the process touched by having to put forward what part of their mandate they believe would affect child health. They actually do it in the cycle before the budget is determined so that those items and ideas are on the table, so the minister responsible for their whole-of-government approach on child health actually has that document in hand before the budget cycle begins.

It is quite a powerful position, and I think it has proven substantially progressive for moving the dial for child health in the province of Manitoba, particularly with their large Aboriginal communities that they have dealt with effectively, particularly in contrast to provinces that have not been able to deal with these public health issues.

I have been very supportive of the whole-of-government approach. I commented on it in my report and it would be of great value for dealing with these issues by the Government of Canada.

Senator Eggleton: What is the position of the minister that has the responsibility in Manitoba for the whole-of-government report? Is it specific to this children portfolio or some other portfolio?

Dr. Leitch: It is specific to this. There is an office of child health for the whole-of-government approach and the minister responsible for child health chairs that cabinet committee and also deals with several of the other health-related issues. It is not just children. They have a whole-of-government approach for other health-related items as well.

Senator Eggleton: Whether you have a human development minister or whatever, you have to have a minister at the cabinet level that will have responsibility for it. A whole-of-government approach involves many ministers, but someone must be the lead.

Dr. Leitch: I agree.

The Chair: Expanding on that, we are recommending that it be the Prime Minister at the federal level and premiers at the provinces. At the civic level it would be the mayor, I suppose. In communities where there are a lot of volunteers, we are still struggling a little bit but we will have to find a way.

Dre Leitch : Je suis tout à fait favorable à une approche réunissant l'ensemble des pouvoirs publics. L'endroit au pays où l'on fait les progrès les plus remarquables relativement à la santé des enfants est le Manitoba, et c'est exactement l'approche qu'on y a mise en œuvre. Les sous-ministres et les ministres sont tous concernés, à un moment ou un autre, par la santé des enfants, à laquelle ils doivent contribuer par des mesures cadrant dans leur mandat. Ils ont à proposer de telles mesures dans le cycle prébudgétaire, de manière à ce que les mesures et les idées qu'ils proposent soient inscrites dans le document qu'a en main le ministre chargé de l'approche réunissant l'ensemble des pouvoirs publics autour de la santé des enfants, avant que le cycle budgétaire commence.

On dispose ainsi de puissants leviers pour agir. Je pense que cette approche a fait ses preuves pour aider le Manitoba à faire un bond en avant dans le dossier de la santé des enfants. Le Manitoba a particulièrement bien réussi avec ses importantes populations autochtones, dont il s'est occupé efficacement, ce qui tranche avec les provinces où l'on n'a pas été capable de faire des progrès concernant les mêmes problèmes de santé publique.

J'ai toujours cru fermement à l'approche réunissant l'ensemble des pouvoirs publics. J'en ai parlé dans mon rapport. C'est une approche qui serait grandement utile pour que le gouvernement du Canada puisse s'attaquer aux problèmes visés.

Le sénateur Eggleton : Quelle est la position du ministre qui est responsable au Manitoba de la mise en œuvre de l'approche mettant à contribution l'ensemble des pouvoirs publics? S'agit-il d'une approche qui est particulière au portefeuille de l'enfance ou à un autre portefeuille?

Dr Leitch : C'est une approche qui est particulière au dossier de la santé des enfants. Il existe un bureau de la santé des enfants où l'on met en œuvre l'approche réunissant l'ensemble des pouvoirs publics. Le ministre chargé de la santé des enfants préside ce comité du Cabinet et s'occupe aussi de plusieurs autres dossiers liés à la santé. On ne procède pas ainsi seulement dans le cas des enfants. L'approche réunissant l'ensemble des pouvoirs publics est employée aussi dans d'autres dossiers relatifs à la santé.

Le sénateur Eggleton : Que ce soit un ministre du développement humain ou un autre ministre, il faut qu'un membre du Cabinet ait la responsabilité du dossier. Une approche réunissant tous les pouvoirs publics nécessite la participation de nombreux ministres, mais l'un d'entre eux doit agir en tant que principal responsable du dossier.

Dr Leitch : Je suis d'accord.

Le président : À cet égard, nous recommandons que ce soit le premier ministre à l'échelon fédéral et les premiers ministres des provinces à cet échelon. À l'échelon municipal, je suppose que ce serait le maire. Pour les milieux où il y a beaucoup de bénévoles, nous avons encore un peu de difficulté à trouver une solution, mais nous allons devoir en trouver une.

Dr. Leitch: You could pick the chair of the YMCA.

The Chair: Thank you very much.

(The committee adjourned.)

Dre Leitch : Vous pourriez choisir le président de l'Alliance universelle des unions chrétiennes de jeunes gens.

Le président : Je vous remercie beaucoup.

(La séance est levée.)

Senate



CANADA

Sénat

A HEALTHY, PRODUCTIVE CANADA: A DETERMINANT OF HEALTH APPROACH

**The Standing Senate Committee on Social Affairs,
Science and Technology
Final Report of
Senate Subcommittee on Population Health**

The Honourable Wilbert Joseph Keon, Chair
The Honourable Lucie Pépin, Deputy Chair

June 2009

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**HEALTH IS LARGELY DETERMINED BY FACTORS OUTSIDE THE
HEALTH CARE SYSTEM:**

[L]ack of health care is not the cause of the huge global burden of illness; water-borne diseases are not caused by lack of antibiotics but by dirty water, and by the political, social and economic forces that fail to make clean water available to all; heart disease is not caused by a lack of coronary care units but by the lives people lead, which are shaped by the environments in which they live; obesity is not caused by moral failure on the part of individuals but by the excess availability of high-fat and high-sugar foods. The main action on social determinants of health must therefore come from outside the health sector.

[from the World Health Organization Commission on Social Determinants of Health, Closing the Gap in a Generation – Health Equity Through Action on the Social Determinants of Health, 2008, p. 35.]

TABLE OF CONTENTS

LIST OF RECOMMENDATIONS	ii
ORDER OF REFERENCE	vii
MEMBERSHIP	viii
LIST OF ABBREVIATIONS	ix
FOREWORD.....	1
INTRODUCTION.....	2
PART I: POPULATION HEALTH AND HEALTH DISPARITIES.....	4
1. POPULATION HEALTH	4
2. FROM HEALTH CARE TO THE DETERMINANTS OF HEALTH.....	7
3. THE EXTENT OF HEALTH DISPARITIES	9
4. THE CASE FOR ACTION, THE COST OF INACTION	16
PART II: HEALTH PAYS OFF – ACT NOW	17
1. WHOLE-OF-GOVERNMENT APPROACH	17
1.1 A Question of Governance	17
1.2 The Need for a Vision	21
1.3 Interdepartmental Spending Review	24
1.4 A Health Lens in all Policies	24
2. DATABASE INFRASTRUCTURE	26
2.1 A Pan-Canadian System of Community Accounts.....	27
2.2 Population Health Intervention Research	30
3. ENGAGING COMMUNITIES	32
3.1 Improving Reporting Requirements.....	32
3.2 Longer-Term Funding	33
3.3 Community Data and Research	34
3.4 Coordinating or Integrating Services: Community Models that Work	35
4. ABORIGINAL POPULATION HEALTH	39
CONCLUSION	42
APPENDIX A	A1
APPENDIX B	B1
APPENDIX C	C1

LIST OF RECOMMENDATIONS

1. That the Prime Minister of Canada take the lead in announcing, developing and implementing a population health policy at the federal level;

That a Cabinet Committee on Population Health be established to coordinate the development and implementation of the federal population health policy;

That the Prime Minister of Canada chair the Cabinet Committee on Population Health;

That the Cabinet Committee on Population Health comprise the relevant departmental ministers including, but not limited to: Human Resources and Skills Development, Indian and Northern Affairs, Finance, Health, Environment, Justice, Agriculture and Agri-Food, Industry, Public Health Agency, and Status of Women.

2. That the Prime Minister of Canada convene a meeting with all First Ministers to establish an intergovernmental mechanism for collaboration on the development and implementation of a pan-Canadian population health strategy;

That the Premiers announce, develop and implement in their respective jurisdiction a population health policy that is modelled on the federal population health policy;

That, in each province and territory, Premiers establish and chair a Cabinet Committee on Population Health.

3. That the Treasury Board of Canada Secretariat pro-actively undertake to enhance the range of models and resources available for the management of horizontal and vertical collaborations.
4. That the Government of Canada increase funding to the Public Health Agency of Canada for the creation of a policy and knowledge node that will act as a resource for the implementation of population health and health disparities reduction policies and initiatives both horizontally (at the federal level) and vertically (through intergovernmental collaboration).
5. That, wherever feasible, local /municipal governments across the country adopt and implement a broad population health

approach within their boundaries and in collaboration with federal, provincial and territorial governments. boundaries and in collaboration with federal, provincial and territorial governments.

6. That the Health Goals for Canada agreed upon in 2005 be revived and guide the development, implementation and monitoring of the pan-Canadian population health policy.
7. That the Population Health Promotion Expert Group accelerate its work to complete within the next 12 months the development of a national set of indicators of health disparities;

That the indicators of health disparities be appropriately matched with the Health Goals for Canada.

8. That the Department of Finance, in collaboration with the Privy Council Office and the Treasury Board Secretariat, conduct an interdepartmental spending review with the aim of allocating resources to programs that contribute to health disparity reduction.
9. That the Government of Canada require Health Impact Assessment (HIA) to be conducted for any policy, plan or program proposal submitted to Cabinet that is likely to have important consequences on health;

That the Privy Council, in collaboration with Health Canada, develop guidelines for implementing the Cabinet directive on HIA;

That the HIA guidelines be developed using existing material;

That the Government of Canada encourage the use of HIA in all provinces and territories.

10. That the Government of Canada support the development and implementation of Community Accounts, modelled on the Newfoundland and Labrador CA, in all provinces and territories.
11. That the Canadian Institute for Health Information (CIHI) be designated as the lead in the development, management and maintenance of the pan-Canadian population health database infrastructure;

That CIHI immediately begin work to establish the necessary vertical integration of data with key partners.

- 12. That Statistics Canada, in collaboration with Canada Health Infoway Inc., the Canadian Institute for Health Information and other key stakeholders, develop standards to facilitate the linkages between the Community Accounts and Electronic Health Records while ensuring the protection, privacy and security of personal information;**

That work on the development of appropriate standards for the protection, privacy and security of personal information be completed within the next 12 months.

- 13. That the Canadian Institutes of Health Research (CIHR) work in collaboration with relevant federal departments and agencies to assess current investment in population health intervention research and reach consensus on and determine an appropriate level of funding in this field;**

That the Government of Canada increase its investment in population health intervention research to match the level agreed upon by CIHR and other relevant department and agencies;

That future population health intervention research funded by the government of Canada build on the capacity and strengths of existing networks and research centres and foster collaborative partnerships among municipal, provincial and federal research agencies as well as academic partners for a focused research agenda;

That the Government of Canada devise competitive operational funding mechanisms that will best support innovative, leading-edge research on population health intervention;

That the Government of Canada consider joint funding mechanisms for inter-provincial and international comparative research on population health interventions;

That the Government of Canada examine the eligibility criteria for human health research infrastructure funds in Canada and consider how these could be better aligned with population

health intervention research involving implementation mechanisms in health and other sectors;

That population health intervention research on housing, early childhood development and mitigating the effects of poverty among Aboriginal peoples and other vulnerable populations be considered priorities.

14. That the Treasury Board of Canada Secretariat review and revise grant and contribution reporting requirements among federal departments and agencies to enhance horizontal and vertical coordination of reporting.
15. That the Treasury Board of Canada Secretariat encourage multi-year funding of projects that have multi-year timelines. The Treasury Board of Canada Secretariat should also encourage multi-year funding among federal granting agencies, where appropriate.
16. That the Government of Canada include support for local analysis and evaluation capacity in the design of programs aimed at improving population health and reducing health disparities.
17. That the Government of Canada work with other levels of government and the non-governmental sector to support the integration or coordination of community-level services within a determinant of health framework.
18. That Aboriginal peoples – First Nations, Inuit and Métis – be involved in the design, development and delivery of federal programs and services that address health determinants in their respective communities.
19. That the Prime Minister of Canada, as a first step toward the development and implementation of a pan-Canadian population health strategy, work with provincial and territorial Premiers, as well as with First Nations, Inuit, Métis and other Aboriginal leaders in closing the gaps in health outcomes for Aboriginal Canadians through comprehensive, holistic, and coordinated programs and services.
20. That the following health determinants be given priority: clean water, food security, parenting and early childhood learning, education, housing, economic development, health care and violence against Aboriginal women, children and elders.

21. That the Government of Canada work with all provincial and territorial governments to implement Jordan's principle for all programs, initiatives and services that address the health determinants of Aboriginal peoples in all age groups
22. That the Government of Canada, in collaboration with its provincial and territorial counterparts, as well as the appropriate First Nations, Inuit and Métis organizations, support and fund appropriate structures and mechanisms across the country that will facilitate the development and implementation of comprehensive, holistic, and coordinated programs and services that address health disparities in Aboriginal communities.

ORDER OF REFERENCE

Extract from the *Journals of the Senate* of Tuesday, February 24, 2009:

The Honourable Senator Eggleton, P.C., moved, seconded by the Honourable Senator Fraser:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report on the impact of the multiple factors and conditions that contribute to the health of Canada's population — known collectively as the determinants of health — including the effects of these determinants on the disparities and inequities in health outcomes that continue to be experienced by identifiable groups or categories of people within the Canadian population;

That the committee examine government policies, programs and practices that regulate or influence the impact of the determinants of health on health outcomes across the different segments of the Canadian population, and that the committee investigate ways in which governments could better coordinate their activities in order to improve these health outcomes, whether these activities involve the different levels of government or various departments and agencies within a single level of government;

That the committee be authorized to study international examples of population health initiatives undertaken either by individual countries, or by multilateral international bodies such as (but not limited to) the World Health Organization;

That the papers and evidence received and taken and work accomplished by the committee on this subject since the beginning of the First Session of the Thirty-Ninth Parliament be referred to the committee; and

That the committee submit its final report no later than June 30, 2009, and that the committee retain all powers necessary to publicize its findings until 180 days after the tabling of the final report.

The question being put on the motion, it was adopted.

Paul C. Bélisle

Clerk of the Senate

MEMBERSHIP

The Honourable, Wilbert Joseph Keon, Chair of the Committee

The Honourable, Lucie Pépin, Deputy Chair of the Committee

The Honourable Senators:

Catherine S. Callbeck

Andrée Champagne, P.C.

Joan Cook

Nicole Eaton

Joyce Fairbairn, P.C.

Ex-officio members of the Committee:

The Honourable Senators: James Cowan (or Claudette Tardif) and Marjory LeBreton, P.C., (or Gérald J. Comeau).

Other Senator who have contributed substantially to this study: The Honourable Senators Eggleton, C.P.

The Committee would like to thank the following staff for their hard work in the preparation of this report:

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2nd Session of the 40th Parliament

Tracy Amendola, Administrative Assistant, 2nd Session of the 39th Parliament

Keli Hogan, Clerk of the Committee, 2nd Session of the 40th Parliament

Monique Régimbald, Administrative Assistant, 2nd Session of the 40th Parliament

LIST OF ABBREVIATIONS

BCHC: British Columbia Healthy Communities

CA: Community Accounts

CIHI: Canadian Institute for Health Information

CIHR: Canadian Institutes of Health Research

CLSC: *Centre local de services communautaires*

CMA : Census Metropolitan Area

COAG: Council of Australian Governments

EHR : Electronic Health Record

EIA: Environmental Impact Assessment

F/P/T: Federal/Provincial/Territorial

HIA: Health Impact Assessment

LEF: Learning Enrichment Foundation

LICO: Low income cut-off

NGO: Non-Governmental Organization

NSERC: National Science and Engineering Research Council

OECD: Organisation for Economic Development and Cooperation

PHAC: Public Health Agency of Canada

SSHRC: Social Sciences and Humanities Research Council

UK: United Kingdom

WHO: World Health Organization

FOREWORD

Canada is generally perceived as one of the greatest countries in the world in which to live. It has a vast and diverse geography rich in natural resources, clean air and a vast territory. When it comes to health however, we unfortunately have serious disparities. Some Canadians live their lives in excellent health with one of the highest life expectancies in the world; paradoxically others spend their life in poor health, with a life expectancy similar to some third world countries. The unfortunate Canadians, who suffer poor health throughout their lifetime, are frequently less productive adding to the burden on the health care delivery system and social safety net. We can not correct this inequity through the health care delivery system itself, regardless of the expenditure we devote to it.

We must change our way of thinking and recognize that good health comes from a variety of factors and influences, 75 percent of which are not related to the health care delivery system. Therefore we must become proactive and support communities, cities, provinces, territories and a country in producing citizens in good health, physical and mental well-being and productivity. Passively waiting for illness and disease to occur and then trying to cope with it through the health care delivery system, is simply not an option. Hence, we must address all of the factors that influence health and through a population health approach, overcome inequities and foster well being and productivity.

The knowledge and technology to do so are now available but more research is required. Change will demand the attention of all individuals, NGOs, businesses, communities, all levels of government and all sectors of our Canadian society. Success will require leadership from our prime minister and first ministers, from our mayors, municipal leaders, community leaders and the leaders of our Aboriginal peoples. A whole of Government approach is required with intersectoral action embracing business, volunteers and community organizations. This will not be easy, but it can and must be done. We cannot afford to do otherwise.

A population health information system with longitudinal capacity that can monitor, evaluate and report on well being throughout the human life course is required. Community initiatives that integrate education, health and social services are required so we can reduce disparities, stem the prevalence of disease and increase productivity. We must not be intimidated by this task, which is doable and which will eventually lead to a nation with health equity, well-being and drastically improved productivity. The challenge is for every Canadian, the benefits are to every Canadian.

INTRODUCTION

Achieving health equity within a generation is achievable, it is the right thing to do, and now is the time to do it.¹

With the tabling of this final report, the Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology has come to the end of a long journey that began in February 2007, during the 1st session of the 39th Parliament, when the Subcommittee received a mandate from the Senate “to examine and report on the impact of the multiple factors and conditions that contribute to the health of Canada’s population – referred to collectively as the determinants of health.” This mandate was renewed in October 2007, at the beginning of the 2nd session of the 39th Parliament, and once again in February 2009 during the 2nd session of the 40th Parliament.

This report is therefore the culmination of a two-year study by the Subcommittee. During this period, the Subcommittee sat for 52 hours, held 30 meetings, heard the views of over 117 witnesses and received hundreds of written submissions. Members also visited 6 Canadian communities and completed a fact-finding mission in one country. We wish to express our sincerest thanks to all those who gave us their advice on what needs to be done to improve the health of Canadians, reduce health disparities and foster Canada’s productivity. We have given serious consideration to their comments and suggestions and find them particularly timely in the context of the current economic slowdown.

Our final report was preceded by four interim reports:

- *Population Health Policy: International Perspectives* presents an analysis of government policy to improve population health and reduce health disparities in Australia, England, Finland, New Zealand, Norway and Sweden. In recent years, many of these countries have taken bold steps to implement whole-of-government approaches to close the gap in health outcomes between healthier and more vulnerable population groups.
- *Maternal Health and Early Child Development in Cuba* summarizes the Subcommittee’s findings on the content, structure, cost, management and impact of maternal health programs and early childhood education initiatives in Cuba. A key player in the country’s successful approach to maternal health and early childhood development is what Cubans call “polyclinics.” The role of the polyclinics is far more extensive than that of a health clinic as Canadians would understand that term. These local establishments ensure integration of science, knowledge transfer, parent education and community mobilization, in the premise of a strong multidisciplinary primary health care sector.

¹ World Health Organization Commission on Social Determinants of Health, *Closing the Gap in a Generation – Health Equity Through Action on the Social Determinants of Health*, 2008. http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

- *Population Health Policy in Canada: Federal and Provincial/Territorial Perspectives* describes previous efforts of the federal, provincial and territorial governments to develop and implement population health policy. Both the federal and provincial/territorial governments have devoted considerable attention to population health over the past 35 years. However, there is still no national plan in Canada to reduce health disparities and improve overall population health status.
- *Population Health Policy: Issues and Options* outlines the major issues facing the development of population health policy in Canada and presents policy options to improve overall health status and reduce health disparities.

These reports served to launch a public debate on the role of governments, more particularly the federal government, in the development and implementation of a determinant of health approach for Canada. They also formed the basis for further hearings and consultations with Canadians from across the country. This final report, which is the result of this consultation process, completes the Subcommittee's journey. It contains recommendations that can be grouped into four categories:

- A new style of governance: leadership from the top to develop and implement a population health policy at the federal, provincial, territorial and local levels with clear goals and targets and a health perspective to all new policies and programs.
- The foundation: a sound population health data infrastructure coordinated by the Canadian Institute of Health Information and based on the Newfoundland and Labrador model of Community Accounts with appropriate linkages to the Electronic Health Records. Statistics Canada and relevant stakeholders will develop standards to ensure the protection, privacy and security of personal information. This database infrastructure will be combined with strong population health intervention research to inform public policy.
- Building healthy communities: because the determinants of health play out at the local level, governments must draw upon and further reinforce the expertise and capacity of citizens to build the strong and inclusive communities that are required for a healthy and productive population. The Cuban polyclinics represent a promising model of intersectoral collaboration at the local level that could be adapted in some Canadian communities.
- A priority focus on First Nations, Inuit and Métis peoples in the development and implementation of a pan-Canadian population health policy and the reduction of health disparities, working with existing leadership to meet current needs, celebrate unique cultures and create new opportunities for the future.

The Subcommittee feels that there is a real window of opportunity for implementing its recommendations. There is a wide range of support from the business sector, rural, urban and Aboriginal communities, non-government organizations, research institutes, universities, professional associations, health authorities, government representatives, etc. Moreover, there is momentum both at the national and international levels with the evidence-based recommendations in the final report of the World Health Organization (WHO) Commission on Social Determinants of Health, the first report of

Canada's Chief Public Health Officer, and the Conference Board of Canada's Roundtable on the Social Determinants of Health, to name a few. Many other countries – such as England, Finland, Norway and Sweden – and a number of provinces – including Newfoundland and Labrador and Quebec – have actively developed actions and programs designed to reduce health disparities and, accordingly, we strongly believe that now is the time for the federal government, in collaboration with other levels of government, to take action on the determinants of health in Canada. In fact, it is not an exaggeration to say that no society can reverse the current downward economic trends and then sustain economic progress if it neglects the health of its people. Not doing so will aggravate the already serious health disparities that exist in this country and compromise future economic prosperity.

PART I: POPULATION HEALTH AND HEALTH DISPARITIES²

1. POPULATION HEALTH

Our study of the determinants of health began with the notions of health and population health. The Subcommittee adopted the well known WHO definition of **health** as “a state of complete physical, mental and social well-being” and “a resource for everyday life”.³ In this perspective, good health is a major source for social, economic and personal development and an important dimension of quality of life. In corollary, the concept of **population health** is based on the understanding that health is determined as much or more by social, economic, environmental and cultural factors than it is by genetic or medical factors. That is, factors such as income, level of education, occupation, social hierarchy and housing, which are all **determinants of health**, have direct and indirect consequences for the health and well-being of the population. Many of these factors play out largely in Canadian communities – the cities, towns, neighbourhoods and regions where people live, learn, work and play. For this reason, the Subcommittee's approach to population health focuses on the **community setting**. Moreover, the impacts of health determinants vary at different stages of people's lives. Accordingly, our population health approach adopts a **lifecourse perspective** – encompassing influences from before birth, through childhood and adolescence, and during adult years. The determinant of health approach envisioned by the Subcommittee is depicted in Chart 1.

(...) I think the issue about population health is not just health; it is population. It is very broad.

*Jean-Marie Berthelot, Vice
President of Programs, Canadian
Institute for Health Information, 27
March 2009 (3:74).*

The combination and interaction of the health determinants result in differences in health status; this in turn gives rise to **health disparities** between individuals and among various segments of the population. There is a wide consensus, both nationally and

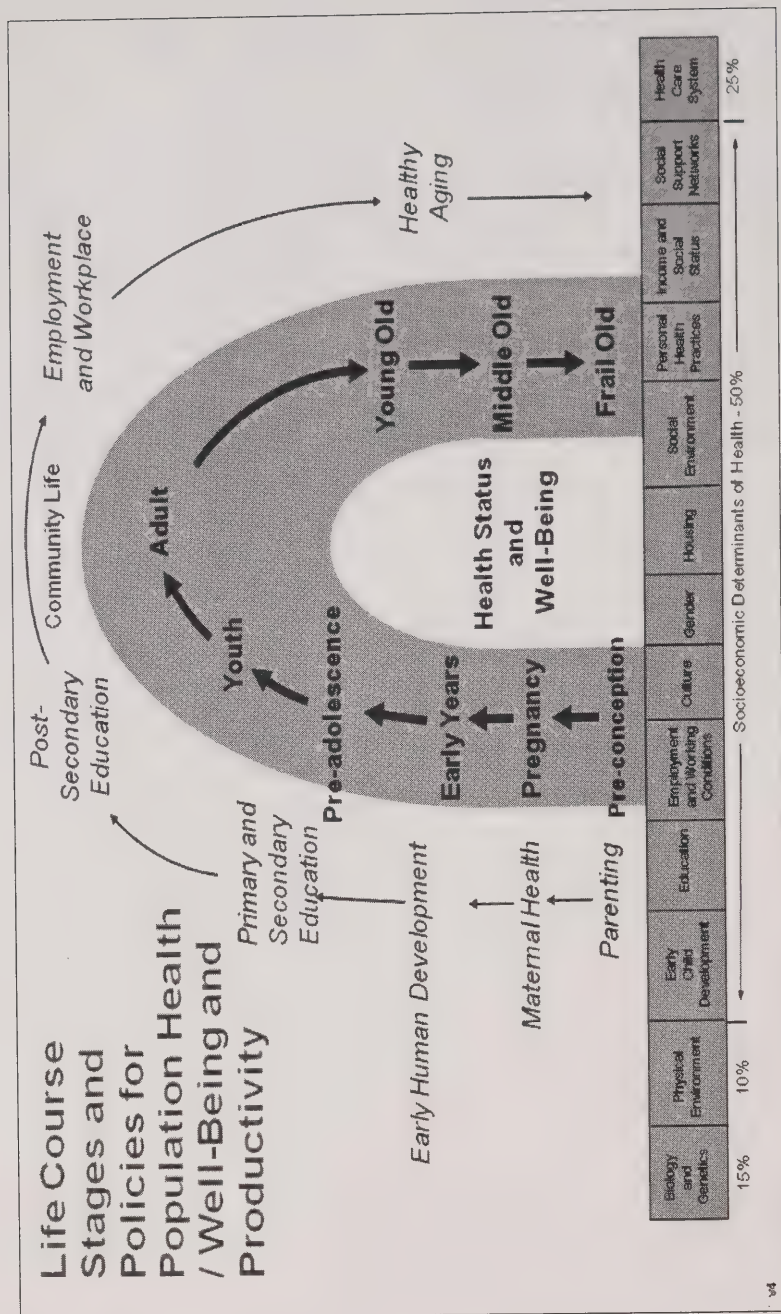
² In this report, the testimony received by witnesses printed in the *Minutes of Proceedings and Evidence of the Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology* will be thereafter referred to only by issue number and page number within the text.

³ World Health Organization, <http://www.who.int/en/>.

internationally, that the vast majority of disparities in health are avoidable, unfair and thus inequitable. These **health inequities** result from the external environment and other social and economic conditions that, while largely outside the control of the individuals affected, are amenable to mitigation by the implementation of well-crafted public policy that we refer to as **population health policy**.

Population health policy is by nature intersectoral – it is designed to address, in a coordinated fashion, the range of determinants that influence health. Such **intersectoral collaboration** has two dimensions: horizontal and vertical. The horizontal dimension links different departments such as education, finance, employment, social services, environment, health, etc. Within a single government, this can be referred to as an interdepartmental or whole-of-government approach. The vertical dimension links sectors at different levels; for example, the federal, provincial/territorial, regional, and local or municipal governments are linked to each other and with groups, institutions, organizations and businesses in the community. Intersectoral action is most successful when it results in a “win-win” situation, whereby the participants at every level gain something.

CHART 1



Source: Parliamentary Information and Research Service, Library of Parliament.

Members of the Subcommittee believe that there is a definitive demand for population health in Canada, but it is not labelled as such. Advocates working against poverty, exclusion, and environmental degradation, like those promoting the status of women, public housing, safe drinking water, and social justice, more broadly all call for action that would reduce disparities and improve health – allowing every Canadian to develop, live and contribute to society to her or his fullest potential. Unfortunately, there is no simple or single terminology to refer to this. While the Subcommittee, along with public health and health promotion experts, refers to it as *population health*, *well-being* and *health inequities*, economists and business entrepreneurs think about it as *human capital*. For their part, social scientists and biologists see it in terms of *human development* while environmentalists address it under the issue of *environmental sustainability*. And for Aboriginal peoples, it is about *holistic health* and *wellness*. No matter how we phrase it, the ultimate goal of this report is to put people – their physical and mental health, well-being and quality of life – at the centre of public policies. This is what the Subcommittee recommends in its call for a determinant of health approach in Canada.

The demand may exist, but it is fragmented and, in my opinion, unidentifiable for the political order at this point in time.

The Honourable Monique Bégin, 18 April 2008 (4:104).

Fundamentally, all roads lead to population health. Whether it is economic issues, income security issues or environmental issues, they all come back to population health.

Mel Cappe, President, Institute for Research on Public Policy, 26 February 2009 (1:15).

2. FROM HEALTH CARE TO THE DETERMINANTS OF HEALTH

As mentioned above, the determinants of health encompass personal, cultural, social, economic and environmental factors. Chart 1 – and evidence from the Canadian literature – suggests that the **health care** system is one contributor to population health, but it only accounts for 25% of health outcomes regardless of the level of funding it receives. Too often, the health care system reacts after the fact, once diseases and illnesses (many of them preventable) have occurred. Clearly, health is more than health care and, of them all, the socio-economic environment is the most powerful of the determinants of health. This emphasizes the need to take an active instead of a passive approach to health and to act before the individual gets sick.

The basic biology and organic make-up of the human body are a fundamental determinant of health, accounting for 15% of health outcomes. In some instances **genetic endowment** appears to predispose certain individuals to particular diseases or health problems.

Housing or lack of adequate housing (overcrowding, substandard dwellings, homes requiring significant repairs, homelessness, etc.) contributes to increased stress, morbidity, mortality, social exclusion, physical and mental illness. Needless to say, health begins at the household level; therefore, promoting population health begins with

having available, affordable and healthy housing. Other human-made elements of our **physical environment**, such as safe workplaces, and communities, well-designed cities, roadways, etc., are vital to a healthy population, as are clear air, water and soil. Overall, some 10% of health outcomes are attributable to the physical environment.

Fully 50% of the health of the population can be explained by socio-economic factors. The social and economic determinants of health are complex and intertwined and we describe some of them below.

Early childhood development, from pre-conception to pregnancy and parenting through the early years of life, is often considered as a powerful health determinant and is a critical element of the life course approach to population health. Scientific evidence demonstrates that experiences from conception to age six have the most important influence of any time in the life cycle on the connecting and sculpting of the brain's neurons. Positive stimulation early in life affects the person's subsequent health, well-being, coping skills and competence.

Education is closely tied to socio-economic status, and effective education for children and lifelong learning for adults are key contributors to health and prosperity for individuals and for the country. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. And it improves people's ability to access and understand information to help keep them healthy. Individual responsibility for health is another important element of a whole-person, whole-government approach to population health.

There is also strong and growing evidence that **income and social status** are positively associated with health. Even more notably, people's health is affected by how wide the difference in income is between the richest and poorest members of the society. So while people with lower income and social status have less control and fewer choices in their lives, this is even more the case when the income gap in the society is very wide.

Evidence shows that **employment and working conditions** have a significant effect on a person's physical and mental health and social well-being. Earned income provides not only money, but also a sense of identity and purpose, social contacts and opportunities for personal growth. When someone loses these benefits, the results can be devastating to both the health of the individual and his or her family.

Finally, the Subcommittee heard evidence of the impact of **culture and gender** on health. Race, ethnicity or cultural background can influence population health by affecting people's vulnerability to the risks to which they are jointly exposed. In addition, society ascribes different roles, personality traits and relative power to males and females, all of which can affect people's health. A gender-based approach to population health recognizes the differences between women and men; this helps identify the ways in which the health risks, experiences, and outcomes are different for women

and men, boys and girls, and to act accordingly. Moreover, a population health approach must be culturally appropriate and flexible enough to take into account the specific needs of the different cultural and ethnic groups that make up our country.

3. THE EXTENT OF HEALTH DISPARITIES

Some Canadians are much healthier than others. Poor health outcomes are more likely among: children and families living in poverty; the working poor; the unemployed/underemployed; those with limited education and/or low literacy; Aboriginal and remote populations; newcomers; persons suffering from social exclusion; the homeless; and those who have difficulty securing affordable housing.⁴

Throughout its study, the Subcommittee received compelling evidence on the extent of health disparities. Wide disparities in health exist among Canadians – between men and women, between regions and neighbourhoods, and between people with varying levels of education and income. Although ill-health is distributed throughout the whole population, it is borne disproportionately by specific groups, notably Aboriginal peoples and individuals and families whose incomes are low.

As shown in Table 1, the difference between health outcomes for Canadians as a whole and for Aboriginal peoples – First Nations, Inuit and Métis – is striking. For example, the average lifespan for Inuit women is 12 years less than the average for Canadian women, while for men the comparable gap is 8 years. Table 1 also shows that the socio-economic status of each Aboriginal group is lower than that of non-Aboriginal Canadians on virtually every measure. Educational attainment is lower, fewer people are employed, and average incomes are lower. Smoking is much more prevalent among Aboriginal peoples than other Canadians. Jeff Reading, Professor and Director, Centre for Aboriginal Health Research, University of Victoria, prepared for the Subcommittee a document which presents the most comprehensive collection of data on the burden of illness and the extent of health disparities among First Nations, Inuit and Métis. His paper acknowledges that the poorer conditions faced by Aboriginal peoples are contributing to their lower health status relative to non-Aboriginal Canadians. These poorer conditions in turn find their origin in the process of dislocation as a result of colonization which rendered Aboriginal peoples and communities as socially excluded from the rest of Canada.⁵

⁴ BC Healthy Living Alliance, *Submission to the Subcommittee*, 8 June 2008, p. 2.

⁵ Jeff Reading, *A Life Course Approach to the Social Determinants of Health for Aboriginal Peoples*, 30 March 2009.

TABLE 1
INEQUALITIES IN HEALTH DETERMINANTS: MUCH REMAINS TO BE
DONE TO IMPROVE THE HEALTH STATUS OF ABORIGINAL PEOPLES

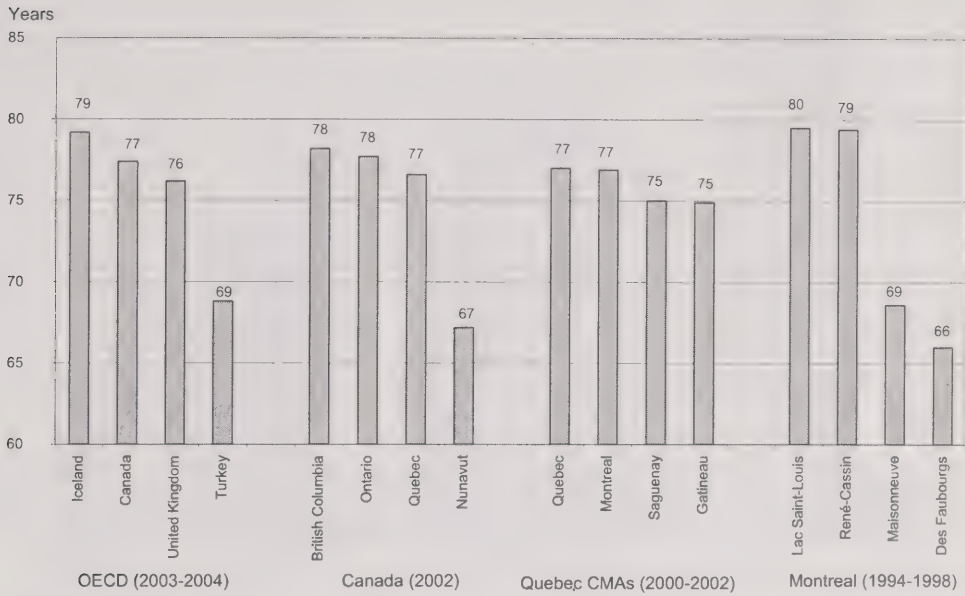
	Non- Aboriginal Canadians	First Nations	Inuit	Métis
Health Status				
Life Expectancy at Birth (Men)	76	69	68	n.a.
Life Expectancy at Birth (Women)	82	77	70	n.a.
Education (% 15 Years and Over)				
No Degree, Certificate or Diploma	33	55	66	46
Bachelor's Degree Graduation	16	4.1	1.9	5.3
Employment (% 15 Years and Over)				
Unemployment Rate	7	22	22	14
Worked Full Year, Full Time	37	23	23	31
Income (% 15 Years and Over)				
Low Income in 2000	16	40	24	28
Lifestyle (% of Population)				
Daily Smoking	22	38	61	37

n.a.: Not available.

Source: Canadian Population Health Initiative, *Improving the Health of Canadians*, 2004.
http://secure.cihi.ca/cihiweb/products/IHC2004rev_e.pdf

The Subcommittee also heard repeatedly about health disparities between and within countries. For example, Chart 2 shows that Canada's life expectancy is one of the highest internationally. However, not all Canadians enjoy a long lifespan. Across the country, there is an 11-year disparity in life expectancy between provinces and territories, from a low 67 years in Nunavut to a high 78 years in British Columbia. Moreover, there are differences within individual provinces. For example, in Quebec, there is disparity in life expectancy between Montreal and Gatineau. Looking even more locally, research by the Montreal public health department estimates a 14-year difference in life expectancy among the areas within the city. These findings highlight the need to adopt a community-level approach to population health.

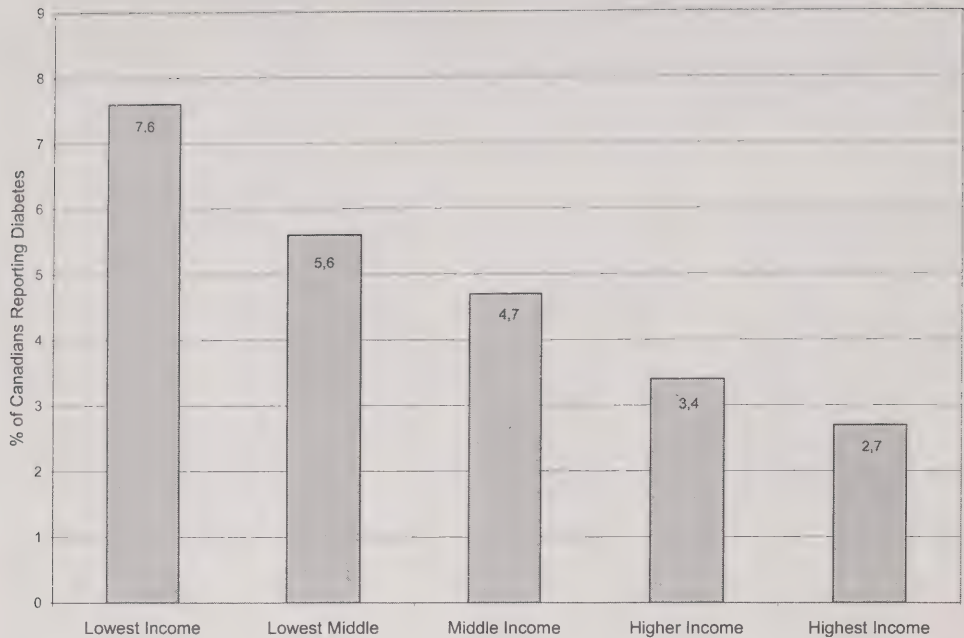
**CHART 2: WHERE YOU LIVE MATTERS TO YOUR HEALTH
DIFFERENCES IN LIFE EXPECTANCY AT BIRTH, MEN**



Source: Reproduced from Glenda Yeates, "Health Disparities in Canada," *Submission to the Subcommittee*, 18 April 2008.

Chart 3 shows that the prevalence of illness – in this particular case diabetes – steadily decreases as income level increases. Put differently, health status improves in a stepwise manner for each increment in income. The presence of this health gradient is not unique to Canada; it has been empirically demonstrated across jurisdictions, nationally and internationally, and at local, neighbourhood and regional levels. However, the level and degree of the gradient slope is not consistent between jurisdictions. The gradient among industrialized nations is steepest in countries such as the United States, and much less steep in countries like Norway and Sweden.

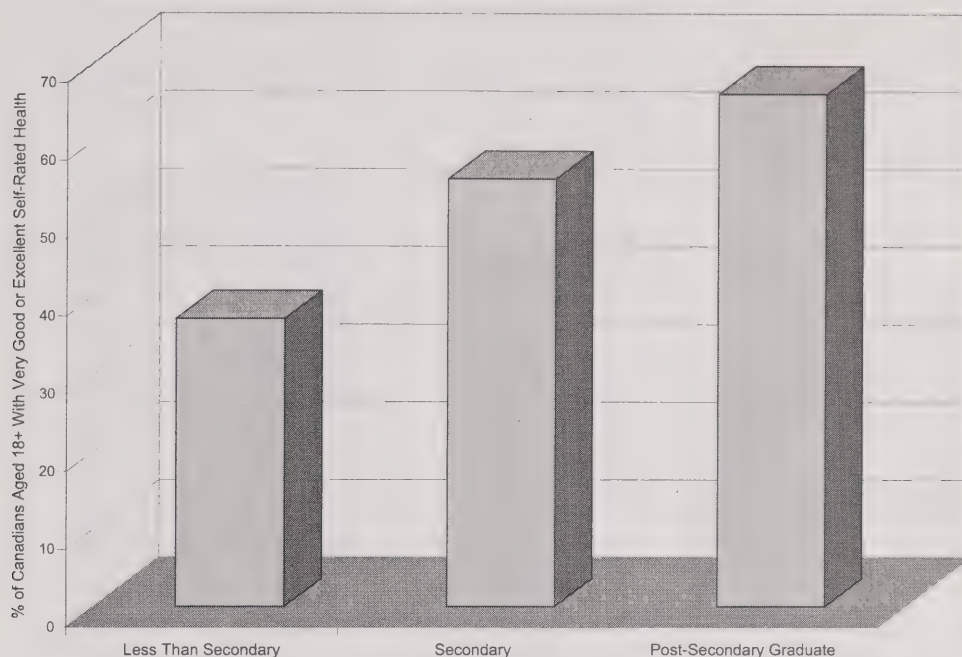
CHART 3: THE SOCIO-ECONOMIC GRADIENT IN HEALTH



Source: Statistics Canada, *Canadian Community Health Survey (Cycle 3.1)*, 2005; Parliamentary Information and Research Service, Library of Parliament.

The 2005 Canadian Community Health Survey reported that Canadians living in households with the lowest levels of education are less likely to report having excellent or very good health. Clearly, Chart 4 shows a health gradient whereby an additional level of education is associated with an increase in the proportion of those reporting excellent or very good health.

CHART 4: EDUCATION IS A STRONG HEALTH DETERMINANT



Source: Statistics Canada, *Canadian Community Health Survey (Cycle 3.1)*, 2005; Parliamentary Information and Research Service.

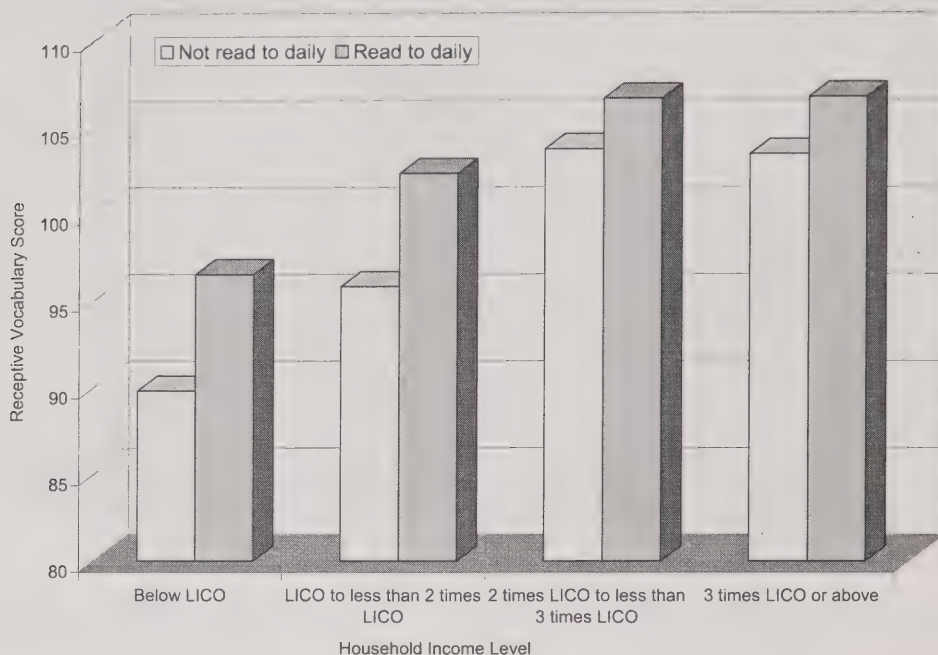
Numerous witnesses stressed the importance of addressing health disparities as early as possible. Chart 5 shows that the health gradient is evident in the earliest years of life. It also indicates that parental involvement in children's early learning is important to success across all incomes. In each household income level, especially among families with the lowest incomes, children who are read to daily have better receptive vocabulary scores than children not read to daily. These are very critical findings, given that human capital in adulthood is to a large extent already determined during childhood. More precisely, measures of child development, such as cognitive and verbal ability, predict measures of human capital in adulthood, such as earnings and employment, as well as involvement in criminal and other risky behaviours. It is not surprising that child development is strongly related to a child's socio-economic background. Many children from disadvantaged families fall

(...) if we do not start to improve the broad determinants of health for our children and youth, it will ultimately have a huge impact on our economy. Children will not be finishing school or going on to post-secondary education and taking on the roles in our economy that we would want for our economy to grow.

*Marie Adèle Davis, Executive Director,
Canadian Paediatric Society, 28 May
2008 (7:21).*

behind early in life and find catching up later very difficult. This underscores the need for a lifecourse approach to population health.

**CHART 5:
THE GRADIENT IN HEALTH IS EVIDENT IN EARLY CHILDHOOD**



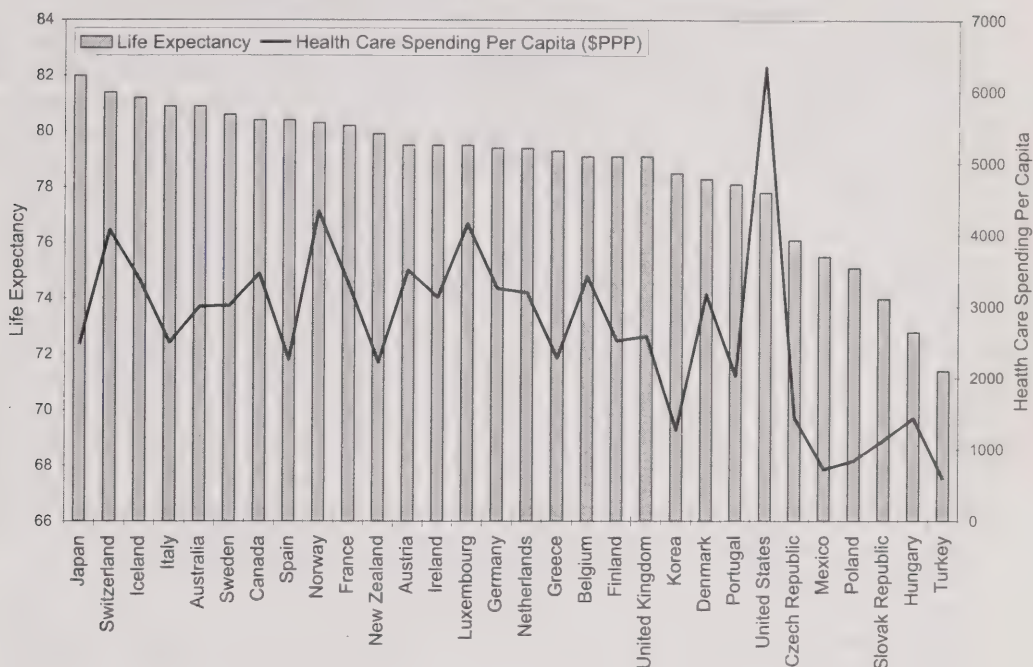
LICO: Low income cut offs.

Source: Reproduced from Eleanor M. Thomas, *Readiness to Learn at School Among Five-Year Old Children in Canada*, Research Paper, Statistics Canada, Catalogue No. 89-599-MIE, 2006, p. 11. <http://www.statcan.ca/english/research/89-599-MIE/89-599-MIE2006004.pdf>

To sum up, the evidence received by the Subcommittee shows that Canadians at the highest levels of education and income are the healthiest and lose fewer years of life to premature death than those with lower education and income levels. It has been estimated that if all Canadians had the same rate of premature death as the most affluent one-fifth of Canadians, there would be a 20% reduction in premature mortality across the population. This would be equivalent to wiping out all premature deaths from either cardiovascular diseases or injuries.⁶

⁶ *The Chief Public Health Officer's Report on the State of Public Health in Canada*, Public Health Agency of Canada, 2008, p. 67. <http://www.phac-aspc.gc.ca/publicat/2008/cpho-aspc/pdf/cpho-report-eng.pdf>

**CHART 6:
INVESTING MORE IN HEALTH CARE –
NO GUARANTEE OF BETTER HEALTH, OECD 2005**



Source: *OECD Health Data, 2008*, and Parliamentary Information and Research Service, Library of Parliament.

Moreover, and we heard this over and over again throughout our study, health is largely determined by factors outside the health care system. Perhaps more importantly, Chart 6 illustrates that spending more on health care is no guarantee for better health. For example, the Euro-Canada Health Consumer Index places Canada 23rd out of 30 in Total Index Score, and 30th out of 30 in Best Value for Money Spent. In other words, this index shows that Canada spends more money on health care to achieve worse results than the other countries surveyed.⁷ Clearly, a determinant of health approach is needed if Canada is to move forward in the economy of the 21st century. In fact, the Subcommittee strongly believes that we cannot afford not to.

⁷ Health Consumer Powerhouse and Frontier Centre for Public Policy, *Euro-Canada Health Consumer Index 2008*, FC Policy Series No. 38. <http://www.fcpp.org/pdf/ECHCI2008finalJanuary202008.pdf>

4. THE CASE FOR ACTION, THE COST OF INACTION

(...) all private sector businesses have good reason to take action on the (...) determinants of health as they will inextricably benefit from healthier employees, customers, and communities generally. In fact, the essential business case for business engagement is about competitiveness, productivity and profitability. Governments and communities wishing to harness the capacity of corporate Canada to drive better health outcomes should recognize this fact and use it to align their efforts accordingly.⁸

Taking action on the determinants of health has the potential to improve population health outcomes by addressing the causes of illnesses and injuries before they occur. There are sound economic and social reasons to improve the physical and mental health of the population. The benefits of population health policy extend beyond improved health status and reduced health disparities to foster economic growth, productivity and prosperity. Good health enables children to perform well in school. Good health enables people to be more productive and higher productivity, in turn, reinforces economic growth. Healthy citizens are better engaged in their communities and this contributes to social cohesion and well-being. A healthy population requires less government expenditures on income support, social services, health care, and security. Simply put, Canada's health and wealth depend on the health of all Canadians.

In the current economic context, population health policy – which puts people's health, lives and well-being at its centre – represents a sound approach to economic recovery. With the economy slowing down, unemployment is on the increase and the living conditions of individuals and families are seriously threatened or already affected. There is a general feeling that there could be devastating long-lasting consequences on health and well-being with growing health disparities, income inequalities and housing and food insecurity. In this perspective, investing in population health should be an integral part of the discussions on economic recovery plans.

Good health is not only a key asset for economic development. In our highly civilized country, health for all must surely be a prime social goal – a responsibility of society as a whole. Health is a fundamental human need and, therefore, a basic human right. Good health is essential for individuals, communities and societies to function well. Therefore, health must be supported throughout all stages of life from conception to childhood through adulthood and old age. In addition, the Subcommittee believes that governments have a moral obligation to foster the social, economic, cultural and environmental conditions that empower individuals, communities and societies to create and maintain good health for all citizens. This is a major challenge that can only be tackled through population health policy, a whole-of-government approach that targets health disparities in all policies (education, social and cultural services, economic policy,

⁸ Conference Board of Canada's Roundtable of the Socio-Economic Determinants of Health, *Submission to the Subcommittee*, 29 June 2008, p. 3.

environmental policy, food policy, income support, housing and infrastructure, taxation, etc). Of course, this will require a profound structural change both in public policy and governments' approach to the development and implementation of public policy.

Certainly, adopting and implementing a population health policy is not without its challenges, but a lack of action will produce more challenges and even greater health disparities in Canada. A lack of action will be very costly in terms of direct health care costs, social costs related to welfare and crime, lost productivity and reduced quality of life. These costs are substantial, have a negative impact on the whole economy and must be borne by all levels of governments and individual households. This report invites all governments – from the federal to the local – as well as businesses, voluntary organizations, communities and citizens, to work together to improve health for all Canadians and reduce health disparities among various population groups.

One problem is that we see the cost of acting but we do not see the cost of not acting. Conditioning must be done to explain to the public that not addressing this problem, whether in social housing, income security or any of these elements, will make things worse down the road. The public says: Do I want my tax dollars going to that problem now? The answer is: Yes, otherwise, we will pay a bigger price.

Mel Cappe, President, Institute for Research on Public Policy, 26 February 2009 (1:22).

The Subcommittee strongly believes that spending on population health is an investment, not an expense. And it is a wise investment with short, medium and long term benefits. Obviously, any spending decision has an opportunity cost. Now we need to prioritize investments to address health disparities. This requires efficiency: making the best use of available resources.

PART II: HEALTH PAYS OFF – ACT NOW

1. WHOLE-OF-GOVERNMENT APPROACH

(...) population health in all the dimensions in which the Subcommittee is examining the issue is clearly a matter of great importance to the government and to the people of Canada. The idea of taking a whole-of-government approach to this important set of issues makes good sense, not least because so many different jurisdictions and institutional actors are in play.⁹

1.1 A Question of Governance

A population health approach requires addressing, in a coordinated fashion, the range of determinants that influence health. Within a single government, this requires a whole-of-government or horizontal approach that brings together different departments and agencies (education, finance, employment, health, environment, etc.). Concerted

⁹ Jim Mitchell, Co-Founder, The Sussex Circle, 26 February 2009 (1:14).

action, collaboration and coordination of efforts on population health – difficult as we realize that is to achieve – is imperative, because the Subcommittee believes it is unacceptable for a privileged country like Canada to continue to tolerate health disparities. It is also imperative in the current economic recession which may lead to a widening of disparities. Doing so, of course, will require a profound structural change in the government’s approach to the development and implementation of public policy. Even though the approach we recommend here does not yet exist, many of the essential components are already in place.

Throughout the study, we asked witnesses how the machinery of government must be structured to accommodate a whole-of-government population health approach within the federal government. How to break down the current silos and enhance horizontality were issues often raised. We heard repeatedly that leadership at the highest levels and from the central agencies is essential for a whole-of-government approach to be successful. Witnesses often mentioned the unique, whole-of-government policy adopted in England to reduce health disparities. The policy, whose implementation was led by the Prime Minister, involved 12 central departments and agencies together with a number of regional and local authorities. Through an interdepartmental spending review, the UK Treasury identified how public spending could best be applied to reduce health disparities. Another noteworthy example of interdepartmental cooperation and coordination is Australia’s approach to “Closing the Gap on Indigenous Disadvantage”; a new initiative led by Prime Minister Kevin Rudd. An Indigenous Affairs Committee of Cabinet has been established to set directions and it is chaired by the Prime Minister. The Cabinet Committee ensures coherent direction across government departments and agencies in the areas of community safety, early childhood, housing, education, health and economic participation.

(...) the critical factor is that the Prime Minister makes this issue a government priority and tells Canadians that it is a government priority.

Jim Mitchell, Co-Founder, The Sussex Circle, 26 February 2009 (1:20).

The question of who should chair a federal “Cabinet Committee on Population Health” was often raised by witnesses. The Hon. Monique Bégin, P.C., former Commissioner, WHO Commission on Social Determinants of Health, recommended that it be chaired by a powerful minister, preferably the Prime Minister or his/her deputy, or the Minister of Finance, but not by the Minister of Health. Other witnesses shared her views. Similarly, the Subcommittee strongly believes that the matter of who chairs the Cabinet Committee on Population Health is crucial since clear direction must come from the Prime Minister on actions to reduce health disparities.

Ministers of health have the biggest share of the government budget. The natural fear of imperialism, which at times is not only a fear but a reality, and the fact that the minister of health is the voice of the most powerful lobby of any society, in my humble opinion and experience, namely, organized medicine, play against these ministers.

Monique Bégin 18 April 2008 (4:105).

Above all, it is clear to the Subcommittee that no one disputes the importance of population health and the need to reduce health disparities. In our view, population health is not a partisan question either. All political parties are committed to reducing health disparities in Canada and, accordingly, this must be top priority on the government agenda. Therefore, the Subcommittee recommends:

That the Prime Minister of Canada take the lead in announcing, developing and implementing a population health policy at the federal level;

That a Cabinet Committee on Population Health be established to coordinate the development and implementation of the federal population health policy;

That the Prime Minister of Canada chair the Cabinet Committee on Population Health;

That the Cabinet Committee on Population Health comprise the relevant departmental ministers including, but not limited to: Human Resources and Skills Development, Indian and Northern Affairs, Finance, Health, Environment, Justice, Agriculture and Agri-Food, Industry, Public Health Agency, and Status of Women.

In a federation where population health policy cuts across federal/provincial/territorial (F/P/T) as well as regional responsibilities, there is a critical need for a coordinating structure to support and enhance consensus and collaboration. It is fair to say that different approaches and priorities across jurisdictions at F/P/T levels have been a constant element of the backdrop to population health policy development and implementation in Canada. The Subcommittee believes that the Prime Minister must, once again, show leadership and engage and support other levels of government in advancing the population health agenda across Canada. We believe that the approach we envision should be applied to all levels of government. Therefore, the Subcommittee recommends:

That the Prime Minister of Canada convene a meeting with all First Ministers to establish an intergovernmental mechanism for collaboration on the development and implementation of a pan-Canadian population health strategy;

That the Premiers announce, develop and implement in their respective jurisdiction a population health policy that is modelled on the federal population health policy;

That, in each province and territory, Premiers establish and chair a Cabinet Committee on Population Health.

In addition to the political leadership and coordinating structures needed to implement federal and provincial population health strategies and policies, many specific models and new mechanisms will be required to advance horizontal (at the federal level) and vertical (intergovernmental) initiatives. Witnesses before the Subcommittee identified many successful models that should be learnt from and, where appropriate, expanded to enhance interdepartmental and intergovernmental collaboration. Federal examples of these include Urban Development Agreements, which bring together federal, provincial and municipal governments to take comprehensive approaches to urban revitalization, Action for Neighbourhood Change, which united a number of federal departments around coordinated action for neighbourhood revitalization, and the Canadian Rural Partnership, which seeks to promote rural considerations across the federal government and in partnership with communities. Provincial examples include Healthy Child Manitoba, and ActNow BC, both of which we profiled in our interim report on F/P/T perspectives.

The lessons from these innovations must be more systematically captured and built upon if we wish to significantly enhance the ability of governments to achieve the degree of horizontal and vertical collaboration needed for population health. Because the Treasury Board of Canada Secretariat is the federal body which establishes the terms and conditions of funding agreements, the Subcommittee recommends:

That the Treasury Board of Canada Secretariat pro-actively undertake to enhance the range of models and resources available for the management of horizontal and vertical collaborations.

The Subcommittee acknowledges that a pan-Canadian effort to reduce health disparities requires both expert knowledge and connectivity. Expert knowledge is needed to support the Cabinet Committee on Population Health and connectivity is required to ensure appropriate links both horizontally and vertically. We believe that the Public Health Agency of Canada (PHAC), which reports to Parliament through the Minister of Health, is well-suited for this undertaking.

PHAC and Health Canada, prior to the Agency's creation, have for many years been at the forefront of research and policy, both domestically and internationally, on population health. Along with the formation of the Agency came the development of the Pan-Canadian Public Health Network which is comprised of federal, provincial and territorial representatives. With this history and these connections, the Agency is well-placed to act as a resource for the transfer of knowledge and effective connectivity that will be required by new collaborative and intersectoral approaches to population health and health disparities reduction. Therefore, the Subcommittee recommends:

That the Government of Canada increase funding to the Public Health Agency of Canada for the creation of a policy and knowledge node that will act as a resource for the implementation of population health and health disparities reduction policies and initiatives both

horizontally (at the federal level) and vertically (through intergovernmental collaboration).

Since most of the determinants of health play out largely at the community level, there is a clear role to be taken by local/municipal governments. Ideally, the same focus and energy on population health by federal and provincial/territorial governments should be applied by local/municipal leaders. We recognize, however, that municipalities have different capacities and resources. Therefore, the Subcommittee recommends:

That, wherever feasible, local /municipal governments across the country adopt and implement a broad population health approach within their boundaries and in collaboration with federal, provincial and territorial governments.

To this point, the Subcommittee has been looking at coordination from the top down. We, however, are convinced that coordination must also be implemented from the bottom up. A top-down commitment and bottom-up input into the delivery system would be a combination that would work. Coordination at the local or community level is discussed in Section 3 below.

1.2 The Need for a Vision

(...) a set of national health goals, provided they are not simply generalities but actually have some substance, would play a major and highly beneficial role in focusing health information development.¹⁰

The ultimate objective of the Subcommittee's recommendations calling for a whole-of-government approach to population health is better health outcomes and the reduction of health disparities. The overarching vision behind our approach, as stated previously, is to allow every Canadian to develop, live and contribute to society to her/his fullest potential. This, in turn, will increase productivity and strengthen prosperity for generations to come. But to have any force, this vision must be grounded in appropriate targets and benchmarks. As can be seen in the following paragraphs, much work has already been done in this area.

The findings of the international and pan-Canadian reviews of population health policy prepared for the Subcommittee suggests that tangible and measurable health goals, objectives and targets are essential components of a whole-of-government approach to population health. They support identification of the areas on which to focus attention, determine the data to collect and indicators to monitor, establish benchmarks, and enable progress to be measured and reported. In the countries profiled, some goals and targets focused on specific health outcomes (e.g., reduced mortality and morbidity), while others focused on the adoption of healthier behaviours; a few countries, like England and Sweden, set targets for the reduction of health disparities.

¹⁰ Michael Wolfson, Assistant Chief Statistician, Statistics Canada, 30 April 2008 (5:9).

In Canada, each province articulated health goals between 1989 and 1998, but by the end of the 1990s they were no longer being applied.¹¹ In 2004, an important step to advance the population health agenda was taken when Canada's First Ministers agreed to commit to the development of "goals and targets for improving the health status of Canadians through a collaborative process with experts."¹² A set of health goals was agreed upon by the F/P/T Ministers of Health in 2005. Goals were developed for each of the following four areas: basic needs in the social and physical environment; belonging and engagement; healthy living; and, a system for health (see table below).

HEALTH GOALS FOR CANADA	
<i>Basic Needs (Social and Physical Environments)</i>	<ul style="list-style-type: none"> • Our children reach their full potential, growing up happy, healthy, confident and secure. • The air we breathe, the water we drink, the food we eat, and the places we live, work and play are safe and healthy – now and for generations to come.
<i>Belonging and Engagement</i>	<ul style="list-style-type: none"> • Each and every person has dignity, a sense of belonging, and contributes to supportive families, friendships and diverse communities. • We keep learning throughout our lives through formal and informal education, relationships with others, and the land. • We participate in and influence the decisions that affect our personal and collective health and well-being. • We work to make the world a healthy place for all people, through leadership, collaboration and knowledge.
<i>Healthy Living</i>	<ul style="list-style-type: none"> • Every person receives the support and information they need to make healthy choices.
<i>A System for Health</i>	<ul style="list-style-type: none"> • We work to prevent and are prepared to respond to threats to our health and safety through coordinated efforts across the country and around the world. • A strong system for health and social well-being responds to disparities in health status and offers timely, appropriate care.

Source: *Health Goals for Canada – A Federal, Provincial and Territorial Commitment to Canadians*, October 2005, <http://www.phac-aspc.gc.ca/hgc-osc/home.html>.

¹¹ Deanna L. Williamson et al., "Implementation of Provincial/Territorial Health Goals in Canada," *Health Policy*, Vol. 64, 2003, pp. 173-191.

¹² First Ministers Meeting, *A 10-Year Plan to Strengthen Health Care*, Ottawa, 14 September 2004, p. 9, http://www.scics.gc.ca/confer04_e.html.

Led by the Public Health Agency of Canada, the Health Goals were developed through a broad consultation and validation process involving provinces, territories, public health experts, stakeholders, and citizens who shared their knowledge and vision for a healthy Canada. Over 300 stakeholders and experts participated in 12 provincial and territorial roundtables, five thematic events, five regional deliberative dialogues and consultations with Parliamentarians. Beyond that, almost 400 individuals, groups, and organizations provided input via an e-survey or by holding their own consultations. This consultation process culminated in the drafting of goal statements, which were validated with government and non-government partners, public health experts, and stakeholders. Although impressive, this thorough consultation process did not evolve into a pan-Canadian strategy nor did it result in any measurable actions.

In light of the international evidence on the implementation of health goals and, despite the lack of progress in this area on the Canadian scene, the Subcommittee concluded in its *Issues and Options* paper “that health goals can aid in mobilizing resources to support population health initiatives, in monitoring and reporting progress, and in stimulating work on the development of health indicators and of health information systems.”¹³ We strongly believe that, if revived, the Health Goals for Canada framework, strengthened by benchmarks and indicators, can potentially serve as a mechanism to guide federal, provincial, territorial and local investments to enhance health. Therefore, the Subcommittee recommends:

I have to say, I do not think Canada needs to go and get new goals. We have goals. We need the indicators, we need the targets and we need the strategies of what, by when, by how. (...) So the overarching goal as a nation is that we aspire to a Canada in which every person is as healthy as they can be, physically, mentally, emotionally and spiritually, is the medicine wheel.

*The Hon. Carolyn Bennett, M.P., 11
June 2008 (7:80).*

That the Health Goals for Canada agreed upon in 2005 be revived and guide the development, implementation and monitoring of the pan-Canadian population health policy.

The Health Goals for Canada must be matched with appropriate indicators/targets on health disparities. Although there is currently no agreed upon national set of indicators of health disparities, work has been undertaken by the Population Health Promotion Expert Group to develop such a set of indicators. The Subcommittee is pleased that this F/P/T Expert Group has been tasked to develop coherent and comprehensive pan-Canadian indicators of health disparities. Therefore, the Subcommittee recommends:

That the Population Health Promotion Expert Group accelerate its work to complete within the next 12 months the development of a national set of indicators of health disparities;

¹³ Subcommittee on Population Health, *op. cit.*, p. 15.

That the indicators of health disparities be appropriately matched with the Health Goals for Canada.

1.3 Interdepartmental Spending Review

In England, the new whole-of-government policy on population health was initiated in response to a 2002 Treasury-led interdepartmental spending review which examined all government programs to identify how public spending could be applied to greatest effect on the reduction of health disparities. The results from this spending review informed departmental spending plans for the 2003-2004 through 2005-2006 fiscal years. Furthermore, the results generated mandatory commitments to actions to reduce health disparities.

At the federal level in Canada, there have been a number of government-wide exercises to review and reallocate expenditures since 2003. The government has explained that, because demands for resources are constantly evolving, programs need to be reviewed on a regular basis. Since there is already a review process in place, the Subcommittee believes that an interdepartmental spending review should be undertaken, similar to the 2002 UK Treasury review, to identify programs that influence health and to reallocate funding to programs that focus on health disparities. Therefore, the Subcommittee recommends:

That the Department of Finance, in collaboration with the Privy Council Office and the Treasury Board Secretariat, conduct an interdepartmental spending review with the aim of allocating resources to programs that contribute to health disparity reduction.

1.4 A Health Lens in all Policies

As noted previously, the most powerful of the determinants of health are not themselves within the purview of the health sector. In fact, policies made in sectors other than health have the greatest potential to improve (or worsen) population health and well-being and reduce health disparities. Accordingly, numerous witnesses stressed that these policies should be assessed for their potential impact on health prior to their implementation. Health impact assessment (HIA) is the formal approach used to predict the potential effects of a policy; particular attention can be also paid to the impact on health disparities. As such, HIA practice is useful in ensuring that health-related issues are considered in government-wide policy making.

In the 1997 Memorandum on Population Health, a recommendation was made to the federal Cabinet that HIA be applied to all federal policies and programs. Although this recommendation was endorsed, subsequent funding cuts impeded its implementation and only Health Canada moved forward to apply a population health lens to its programs and initiatives. Since then, Health Canada has published, in collaboration with the F/P/T Committee on Environmental and Occupational Health, the *Canadian Handbook on*

Health Impact Assessment.¹⁴ Similarly, the use of HIA has been promoted in a number of provinces and several provincial reports have recommended that HIAs be included in all Cabinet submissions. In 1993 in British Columbia, mandatory HIA was integrated in the formal process of policy analysis at the Cabinet level, but the practice was made optional in 1999 following a change in government.

In some countries, like Sweden and New Zealand, as well as in the province of Quebec, public health legislation has been employed to embed HIA as an integral component of governmental policy development. The Quebec legislation empowers the Minister of Health to issue proactive advice to other Ministers with the goal of promoting health and supporting policies that foster the health of the population. To assist other ministries in their use of HIA, the health ministry (*Ministère de la santé et des services sociaux du Québec*) produced its own HIA guide based on models developed in Europe and adapted to interdepartmental needs.¹⁵ To date, HIA in Quebec has been used, for example, to ban cell phone use in cars and to regulate asbestos mining.

During the Subcommittee's hearings, some witnesses referred to the current federal environmental impact assessment (EIA) process as an example of a successful impact assessment tool. A Cabinet directive calls for strategic environmental assessments to be conducted for any policy, plan or program proposal that is submitted to a Minister or to Cabinet for approval and that is likely to have important environmental effects, positive or negative. The directive also establishes criteria to help federal departments and agencies determine when such an assessment is appropriate, and offers guidance on its preparation.¹⁶ The Canadian Environmental Assessment Agency assists departments on improving their EIA capacity. The Minister of Environment is responsible for advising other ministers on potential environmental considerations of proposals before Cabinet decisions are taken, and for advising on environmentally appropriate courses of action. This does not constitute either a veto or an approval role. In performing their duties, all individual ministers adhere to the government's broad environmental objectives and sustainable development goals. Under the *Auditor General Act*, the Commissioner for the Environment and Sustainable Development is tasked with overseeing the government's efforts to protect the environment and promote sustainable development. The Privy Council Office also plays a role, as it must ensure that departments and agencies are compliant with the directive when they review proposals going to cabinet. As well, Environment Canada provides expert advice.

In its *Issues and Options* report, the Subcommittee stated: "The Subcommittee believes that HIA could be considered as one of the first steps towards the development

¹⁴ Health Canada, *Canadian Handbook on Health Impact Assessment*, 2004, http://www.hc-sc.gc.ca/ewh-scmt/pubs/eval/handbook-guide/vol_1/index-eng.php.

¹⁵ Ministère de la santé et des services sociaux (Québec), *Guide pratique : Évaluation d'impact sur la santé lors de l'élaboration de projet de loi et de règlement au Québec*, 2006, <http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2006/06-245-01.pdf>

¹⁶ Privy Council Office, *Strategic Environmental Assessment – The Cabinet Directive on the Environmental Assessment of Policy, Plan and Program Proposals*, 2004, http://www.ceaa-acee.gc.ca/016/CEAA-StrategieFinal_e.pdf

of population health policy. Such assessments would lead to a better understanding of how most public policies influence population health in one way or another. In our view, HIA is a practical way to judge the potential health effects on the population of a given policy, program or project and in particular on vulnerable or disadvantaged groups; it could maximize the positive and minimize the negative health effects of proposals coming forward from all sectors of government.”¹⁷

Significantly, on the basis of the testimony received, we believe that Canada already has the assets it needs to use HIA as a strategy for developing and implementing population health policy. In our opinion, legislation may not constitute the most effective means of institutionalizing HIA; it may also be a lengthy process. However, a Cabinet directive, similar to the EIA process, would be needed to impose HIA implementation. Therefore, the Subcommittee recommends:

That the Government of Canada require Health Impact Assessment (HIA) to be conducted for any policy, plan or program proposal submitted to Cabinet that is likely to have important consequences on health;

That the Privy Council, in collaboration with Health Canada, develop guidelines for implementing the Cabinet directive on HIA;

That the HIA guidelines be developed using existing material;

That the Government of Canada encourage the use of HIA in all provinces and territories.

2. DATABASE INFRASTRUCTURE

The whole-of-government approach to population health envisioned by the Subcommittee must rest on the development of a sound database infrastructure that will ensure the collection, monitoring, analysis and sharing of population health and health disparity indicators and an ambitious program of intervention research. All the countries profiled by the Subcommittee – Australia, England, Finland, New Zealand, Norway and Sweden – have established sound databases to collect and monitor indicators of health. National institutes of public health monitor and report regularly on population health in Norway, Sweden and Finland. The extent of health disparities is particularly well documented in England and New Zealand.

How does Canada compare in terms of collecting, monitoring and reporting on health outcomes and health disparities? The evidence obtained by the Subcommittee suggests that Canada has sound data on population health status by determinant and on health disparities. At the national level, reliable information is provided by Statistics Canada, the Canadian Population Health Initiative, the Public Health Agency of Canada

¹⁷ Subcommittee on Population Health, *op. cit.*, p. 16.

and Human Resources and Skills Development Canada, while several useful provincial sources of health indicators and health disparities are available including, to name a few, the Manitoba Population Health Data Repository, the Community Accounts in Newfoundland and Labrador, and the British Columbia Health and Wellness Survey. In addition, several community-based indicators of health and well-being are provided by government and non-governmental organizations including, for example, the Rural Secretariat (community information database), the Federation of Canadian Municipalities, the Atkinson Charitable Foundation and the Canadian Council on Social Development. Altogether, these sources of information are assets that can facilitate the development of the focused knowledge and evidence needed to move the population health agenda forward.

2.1 A Pan-Canadian System of Community Accounts

(...) Community Accounts is a fantastic resource. I cannot imagine my job without it; nor can I imagine any other province not having it. Community Accounts provides outstanding information that is very user-friendly, and the data can be very easily transferred into knowledge to help us better the health of our communities.¹⁸

The Subcommittee heard repeatedly that, while Canada has excellent national and provincial population health data and information, it lacks strong data at the local level. Since much of the intersection of policy domains that affect population health occurs at the local level, more local information is needed. Numerous witnesses suggested that the Newfoundland and Labrador Community Accounts (CA) could be a model for the national database infrastructure needed for the implementation of a broad population health policy. Nova Scotia has implemented a version of the CA (Community Counts) and Prince Edward Island recently established CA pilot projects (within the Quality of Island Life Cooperative). The CA also offers potential for Aboriginal communities and is in fact being considered as a database model by the First Nations Statistical Institute.

The CA is an Internet-based retrieval and exchange system that provides unrestricted, free access to view and analyze social, economic and environmental data (health, income, education, employment, production, resources, crime, etc.) from a variety of sources (Statistics Canada, government departments, hospital records, etc.) at the local, regional and provincial levels. The basic building block for geography across the various data sources under the CA is the postal code. The CA is administered by the Newfoundland and Labrador Statistical Agency and is maintained within the provincial Department of Finance. It has many users, including government departments, regional authorities, communities, academia and researchers, NGOs and individuals. The CA is a key supplier of the information necessary to monitor and evaluate progress made under various provincial public policy initiatives, including the Reducing Poverty Action Plan, the Provincial Wellness Plan and the Rural Secretariat.

¹⁸ Lisa Brown, Planning Specialist, Eastern Health, Newfoundland and Labrador, 21 May 2008 (6:121).

It is the view of the Subcommittee that the CA has been very successful in linking information about population health, community well-being, and economic development. We are particularly impressed by the progress achieved in Newfoundland and Labrador in the implementation of a sound population health database infrastructure and are pleased to see that Nova Scotia and Prince Edward Island have adopted a similar database infrastructure model. We believe that such a database is a key asset in the development and implementation of a pan-Canadian population health policy. Therefore, the Subcommittee recommends:

That the Government of Canada support the development and implementation of Community Accounts, modelled on the Newfoundland and Labrador CA, in all provinces and territories.

Another infrastructure system that offers tremendous potential for population health in Canada relates to the Electronic Health Records (EHRs) that are currently being implemented by Canada Health Infoway Inc. in collaboration with provincial and territorial governments. The EHRs contain patient health information and link various care providers within and between jurisdictions. Health information is vast and can include clinical reports, immunization data, dispensed prescription drugs, laboratory test results, diagnostic images, and past and current health conditions. As such, EHRs can provide the life course or longitudinal information that is needed for population health purposes – from pregnancy, to early child development, to schooling and adolescence, to the world of work, then retirement through old age. Moreover, like the CA, the EHRs can be aggregated and analyzed by postal code. Accordingly, numerous witnesses told the Subcommittee that there is a huge opportunity to link, for each Canadian, the data generated by emerging EHRs to a broader CA database infrastructure.

The potential exists for electronic health records to contribute to the data and information system components and could help form part of a foundation for a population health information system.

*Mike Sheridan, Chief Operating Officer, Canada Health Infoway Inc.,
27 March 2009 (3:44).*

Given the several existing national, provincial and local sources of information on health disparities, the Subcommittee often asked witnesses who should take the lead in facilitating the establishment, management and maintenance of a national database system built on the CA and EHRs. Numerous witnesses made the plea to not create more organizations but instead to establish a partnership among the key organizations. There was strong consensus that CIHI – the Canadian Institute for Health Information – has been a successful model of partnership in Canada. Though it is a small organization, CIHI has worked to build the bridges across many other groups working at the national level, as well as across the provinces and territories. The Subcommittee concurs with witnesses that CIHI has effectively been, for the last 15 years, the repository of health information, working in partnership with all provinces and territories. Its capacity and reputation are time-proven. The next step, in our view, is for CIHI to extent its partnerships with other key stakeholders in the broad population health field. Therefore, the Subcommittee recommends:

That the Canadian Institute for Health Information (CIHI) be designated as the lead in the development, management and maintenance of the pan-Canadian population health database infrastructure;

That CIHI immediately begin work to establish the necessary vertical integration of data with key partners.

Witnesses stressed that linking EHR data to the CA database, however, is highly sensitive from a privacy perspective.

The Subcommittee is aware that the right to privacy and confidentiality of personal health information is a very important value for Canadians. Now more than ever, Canadians need reassurance that their privacy and confidentiality will be respected in this era of rapidly advancing technology. However, there is a need to find a good balance between protecting the information of individuals and allowing the use of information on a population group to inform public policies and strategies. The Subcommittee is aware that Statistics Canada has the strongest constitutional and legislative mandate of any organization in the country for these kinds of data linkages, as well as an unblemished record for confidentiality and privacy protection, and a history dating back to the 1960s for technical excellence and leadership in this area. Therefore, the Subcommittee recommends:

We must acknowledge that health information – and I say “information” because it is beyond health, it is social services and unemployment information – is a public good. (...) We must use all the information we collect on citizens in order to learn about the society; where we are, where we are going, how we are going, how we compare across the country and how we compare with other countries. That is critical in terms of effectively facilitating the collection of that information.

Jean-Marie Berthelot, Vice-President of Programs, Canadian Institute for Health Information, 27 March 2009 (3:56).

That Statistics Canada, in collaboration with Canada Health Infoway Inc., the Canadian Institute for Health Information and other key stakeholders, develop standards to facilitate the linkages between the Community Accounts and Electronic Health Records while ensuring the protection, privacy and security of personal information;

That work on the development of appropriate standards for the protection, privacy and security of personal information be completed within the next 12 months.

2.2 Population Health Intervention Research

The Subcommittee heard repeatedly that good public policy requires evidence of effectiveness, both prospectively during the phase of policy design, and on a continuing basis once the policy has been implemented. This evidence in turn depends on skillful and thoughtful analysis, which correspondingly must be grounded in appropriate data and information. Since knowledge about population health is incomplete, and will almost certainly remain so for the foreseeable future, policy development and implementation will inevitably occur in a milieu of incomplete knowledge of what works. For this reason, continuous monitoring and evaluation of policies and programs, with regular feedback to policy design, is essential. Over time, this type of research – often referred to as “population health intervention research” – will help increase our understanding about what policies and programs are effective in improving population health and reducing health disparities.

Now I want to turn to the second issue of investing in more population health research and enhancing the translation of knowledge. Here I want to stress that there are two things we can do, one of which I think would be a mistake. The mistake would be to invest mostly in learning about the general determinants of health outcomes. That is the easy road, but we already know a lot about this. What we need to do is fill the enormous gap in our knowledge of what public policy interventions work. This starts to sound like program evaluation, which it largely is, but it is unbiased program evaluation adhering to high standards of quality. It is also done to consistent standards of methodology so that one can have confidence in relative benefit-cost ratios of different interventions. In Canada we have underinvested by a substantial margin in unbiased, high quality, peer-reviewed, dispassionate effectiveness evaluation, especially in the population health field.

Cliff Halliwell, Director General, Strategic Policy Research Directorate, Human Resources and Social Development Canada, 14 May 2008 (5:12-13).

As the Subcommittee noted in its *Issues and Options* paper, it is not clear how much Canada spends on intervention research.¹⁹ Currently, a number of federal agencies and departments play a role in the direction, funding and design of population health research, including the Canadian Institutes of Health Research, Statistics Canada, the Canadian Institute for Health Information, Health Canada, the Public Health Agency of Canada (and its 6 National Collaborating Centres), other federal departments (such as Indian and Northern Affairs Canada, Human Resources and Skills Development Canada, Environment Canada, etc.) and other research granting agencies such as the Natural Sciences and Engineering Research Council of Canada (NSERC) or the Social Sciences and Humanities Research Council (SSHRC). In addition, there are multiple provincial departments, agencies and institutes involved in intervention research. However, witnesses stressed that current funding does not reflect the burden of health disparities and that more practical, evidence-based knowledge is needed about what improves the health of the population. The Subcommittee believes that intervention research is an essential component of a whole-of-government approach to population health. Therefore, we recommend:

¹⁹ Subcommittee on Population Health, *Population Health Policy: Issues and Options*, April 2008, p. 13.

That the Canadian Institutes of Health Research (CIHR) work in collaboration with relevant federal departments and agencies to assess current investment in population health intervention research and reach consensus on and determine an appropriate level of funding in this field;

That the Government of Canada increase its investment in population health intervention research to match the level agreed upon by CIHR and other relevant department and agencies;

That future population health intervention research funded by the government of Canada build on the capacity and strengths of existing networks and research centres and foster collaborative partnerships among municipal, provincial and federal research agencies as well as academic partners for a focused research agenda;

That the Government of Canada devise competitive operational funding mechanisms that will best support innovative, leading-edge research on population health intervention;

That the Government of Canada consider joint funding mechanisms for inter-provincial and international comparative research on population health interventions;

That the Government of Canada examine the eligibility criteria for human health research infrastructure funds in Canada and consider how these could be better aligned with population health intervention research involving implementation mechanisms in health and other sectors;

That population health intervention research on housing, early childhood development and mitigating the effects of poverty among Aboriginal peoples and other vulnerable populations be considered priorities.

3. ENGAGING COMMUNITIES

*The surprising consistency with which health determinants emerged in our consultations with community-based organizations across Canada suggests that there is already an implicit consensus on these issues. It is safe to conclude that community-based organizations represent a rich resource just waiting to be tapped. The federal government can mobilize this resource by supporting communities to engage in intersectoral action (...).*²⁰

Over the course of our study, the Subcommittee heard from a wide range of witnesses and received numerous briefs that proposed a variety of approaches to improving population health and reducing health disparities. But one critical factor was never in dispute: governments cannot act alone. The most effective actions to improve health and well-being, enhance productivity, foster social cohesion and reduce crime must be taken at the community level, and led by communities themselves.

We agree with the Chief Public Health Officer of Canada who, in his first report (2008), explicitly called for the strengthening of Canadian communities to address health determinants, noting that people living closest to the problem are often closest to the solution. The report stated that communities must be honoured and supported to develop their own locally-appropriate responses, building on existing knowledge, experience and energy. Interventions at the community level are most successful in reaching vulnerable populations, creating local networks, and leveraging resources. Similarly, a 2008 report published by the Canada West Foundation emphasized that the only long-term solution to street-level social issues is the prevention made possible by building strong and inclusive communities.²¹

The leadership has to come not only from the federal government – and I believe the federal government has a key role – but it has to come from the bottom as well. That is the only way this is going to work.

Debra Lynkowski, Chief Executive Officer, Canadian Public Health Association, 18 April 2008 (4:83).

How best to enable and support communities to take that initiative is a new role that governments are learning. Many of the recommendations in this report are designed to support the shift in this new role, including the way data is gathered and shared, how and what kind of research is undertaken, and why a whole-of-government approach is so vital. But for communities to be successful in their efforts, changes are also required in the way governments partner and support those initiatives.

3.1 Improving Reporting Requirements

A significant measure of success of the whole-of-government approach described in Section 1 will be the extent that communities are able to address complex issues with integrated,

²⁰ Canadian Mental Health Association, *Submission to the Subcommittee*, 2008, p. 5.

²¹ Canada West Foundation, *From the Ground Up: Community's Role in Addressing Street-Level Social Issues* (2008). http://www.cwf.ca/V2/cnt/publication_200810271452.php

intersectoral responses that are supported by a range of departments and agencies from different levels of government.

Because programs supporting the determinants of health span numerous departments, initiatives taking an integrated approach to action on the determinants of health could be eligible for funding from multiple sources. The report of the Independent Blue Ribbon Panel on Grant and Contribution Programs recommended that policies should encourage reporting in ways that meet the accountability requirements of all the federal programs involved, so that a recipient receiving funding from different programs can consolidate reporting.²² This may require legislative amendments to clarify concepts of ministerial accountability, but would permit Treasury Board to take a more holistic, responsive and coordinated approach to community investments.

Similarly, jurisdiction for the determinants of health extends across all three levels of government. For this reason, the Independent Blue Ribbon Panel report also recommended that the Treasury Board and its Secretariat, in cooperation with other orders of government, harmonize federal, provincial and municipal information, reporting and audit requirements for grants and contributions. Basing reporting requirements on existing instruments that strengthen accountability, not only to governments but also to the organization's primary constituency (its members or community), will reduce administrative burden and enhance local leadership. It is fair to say that harmonization of reporting and auditing requirements will clearly be facilitated by the implementation of Community Accounts across the country. Therefore, the Subcommittee recommends:

Current funding regimes and accountability actually work to curtail innovation.

*Katherine Scott, Vice-President,
Research, Canadian Council on
Social Development, 12 March
2009 (2:12).*

That the Treasury Board of Canada Secretariat review and revise grant and contribution reporting requirements among federal departments and agencies to enhance horizontal and vertical coordination of reporting.

3.2 Longer-Term Funding

Action on the determinants of health can often take many years before results are seen in terms of improved health status or reduced health disparities. The Subcommittee heard repeatedly that short-term, project-based funding as a principal source of revenue weakens community organizations by instilling insecurity and preventing long-term planning. Multi-year funding agreements, subject to annual appropriations by Parliament, would provide stability in the sector and reduce transaction costs for the government. Therefore, the Subcommittee recommends:

That the Treasury Board of Canada Secretariat encourage multi-year funding of projects that have multi-year timelines. The Treasury Board of

²² From *Red Tape to Clear Results: The Report of the Independent Blue Ribbon Panel on Grant and Contribution Programs*, December 2006, http://www.brp-gdc.ca/pdf/Report_on_Grant_and_Contribution_Programs.pdf.

Canada Secretariat should also encourage multi-year funding among federal granting agencies, where appropriate.

3.3 Community Data and Research

The determinant of health framework presented in Chart 1 illustrates how population health is a complex, long-term and dynamic goal. A specific intervention that works in one community at one time may not work in another community or even in the same community at a later time. Each set of circumstances is unique, so local leadership is required to draw upon the experience of what has worked elsewhere, adapt it to local realities, constantly evaluate and learn what works.

This cycle of taking action, evaluating, learning and adjusting requires that community leaders have access to local data. Local data has to be extremely refined – down to the neighbourhood or postal code level. An analysis of data at the postal code or neighbourhood level can reveal shocking disparities between local areas – the differences in life expectancy between neighbourhoods in Montréal illustrated in Chart 2 above is just one example. Another was provided by Dr. Robert Cushman when he described differences between two Ottawa neighbourhoods – the Glebe and Dalhousie – which, despite their geographic proximity, are respectively among the richest and the poorest neighbourhoods in Ottawa. Since income is such a significant determinant of health, it should not be surprising that heart disease and diabetes are two to four times more common in Dalhousie than in the Glebe.²³ Regrettably, many cities across Canada also likely have similar contrasting neighbourhoods. Because of the large disparities, actions to improve health and reduce health disparities will almost certainly have to be tailored to the different realities of each neighbourhood, but those actions must be informed by easily accessible neighbourhood-level data, down to the level of the postal code.

That is another strength of the Community Accounts model recommended above – it puts data into the hands of local decision-makers. It also brings together data from a range of federal and provincial sources to one location, presenting a comprehensive picture at the local level. The data alone, however, is not sufficient. Local capacity also has to be in place to analyze and interpret that data into meaningful feedback that can guide decision-making about local initiatives on the determinants of health. Furthermore, intervention research that can uncover the essential characteristics of successful (and unsuccessful) initiatives will contribute to our understanding of what works and facilitate the useful transfer and application of those lessons to new settings.

The key to data analysis and research is that it should be done in a way that empowers communities and builds local capacity for action over the long term. This means building in funds for research and evaluation in any program agreement. It is this evidence-based system of learning and action that will be the foundation for improving population health and reducing health disparities. Therefore, the Subcommittee recommends:

That the Government of Canada include support for local analysis and evaluation capacity in the design of programs aimed at improving population health and reducing health disparities.

²³ Dr. Robert Cushman, Chief Executive Officer, Champlain Local Health Integration Network, 1st April 2009 (:).

The federal government plays an important role in direct support to local organizations and firms. More than 50 federal departments and agencies spend nearly \$27 billion each year through more than 800 grant and contribution programs.²⁴ Yet governmental funding structures, which are usually focussed on addressing specific issues, tend to fragment community strategies, isolating target populations and separating sectors of activity.

A number of initiatives have been undertaken in recent years to improve funding and accountability relationships between the federal government and the voluntary / non-profit sector, including the Voluntary Sector Initiative, the Task Force on Community Investments and the Independent Blue Ribbon Panel on Grant and Contribution Programs. These efforts have made some progress, but much more remains to be done. Two of the most fundamental changes that will be required to strengthen community capacity and support community-level action on the determinants of health involve improving reporting requirements and providing longer-term funding.

3.4 Coordinating or Integrating Services: Community Models that Work

Because population health is a complex and dynamic objective, coordinated action on many or all of the determinants of health at the local level is required in order to begin showing overall improvements in health outcomes. Once communities have the information and analysis necessary to properly identify and monitor the challenges they face, they must take a coordinated and strategic approach to act on those determinants locally.

Just as Canada is defined by a richly diverse social fabric, the coordinated or integrated approaches by which communities address health determinants can take many forms. The Subcommittee has been extremely impressed to learn about the wide range of successful initiatives contributing to good health, well-being, low crime and productivity in rural, urban, Aboriginal and other settings. New community-based practices, such as community economic development and the social economy, often address many of the determinants of health in a coordinated manner while empowering citizens. These integrated, locally based approaches consciously blend a range of social, economic and environmental objectives that can improve many of the determinants of health, especially for marginalized and minority groups. They are rooted in communities, depending on volunteer involvement and guided by citizens for the actions they take. It is worth mentioning a few examples here.

While in St. John's, Newfoundland and Labrador, the Subcommittee had the pleasure of visiting Stella Burry Community Services and enjoying a superb lunch at Stella's Circle restaurant. Stella Burry Community Services serves adults with social and emotional problems by: providing support and counselling to individuals who have experienced significant personal troubles such as abuse, addictions, violence and incarceration; developing affordable housing for low income individuals and families, and; offering training and skills development programs. Stella's Circle is a social enterprise started by Stella Burry Community Services in order to provide job creation and skills training opportunities in the food services industry, to offer low-cost meals to members of the Stella Burry community who are challenged to maintain good nutrition on limited incomes, and to act as a source of revenue generation for the organization.

²⁴ Report of the Independent Blue Ribbon Panel on Grant and Contribution Programs, *op. cit.*

Through the combination of these initiatives, Stella Burry is able to address many more of the determinants of health in an integrated manner for the population they serve.

Also while in St. John's, the Subcommittee learned about the Tamarack Institute's Vibrant Communities initiative. Vibrant Communities is a community-driven effort to reduce poverty in 15 cities by supporting collaborative local initiatives aimed at poverty reduction that engage the private sector and can improve numerous determinants of health. In St. John's, one of the Vibrant Communities' projects is the Citizen's Voice Network that meets regularly to share information, to learn, and collectively to impact policy-making and decision-making.

Social planning councils such as the Human Development Council in St. John, New Brunswick also make a valuable contribution in working with citizens and connecting community services to improve overall quality of life. The Human Development Council performs two key functions: an information role linking citizens to human services, and a proactive role developing solutions to meet community challenges.²⁵ The New Brunswick Premier's Community Non-Profit Task Force report insightfully advocates for more horizontal regional structures working through community organizations, with regional autonomy for service delivery, making flexibility easier and encouraging an integrated approach to individual and community issues.²⁶

Québec has a vibrant community sector, with a number of different structures helping facilitate coordinated local action. There are almost 50 Community Development Corporations that bring together community organizations from a range of different sectors to facilitate training, information sharing, and supporting joint responses to local social issues.²⁷ Linking social, economic and environmental determinants of health locally, fourteen Community Economic Development Corporations help communities develop and implement their own solutions to economic problems by mobilizing local residents, businesses and institutions.²⁸ The Québec Network of Healthy Cities and Towns inspired *Vivre St-Michel en santé*, a local action committee made up of residents, community groups, businesses and government agencies committed to revitalizing the Montréal neighbourhood.²⁹ *Vivre St-Michel en santé* led a year-long consultation, planning and research process that involved 400 community members and stakeholders, and resulted in a comprehensive community plan to improve social and economic conditions.

In Ontario, the Learning Enrichment Foundation is one of the oldest and largest community economic development organizations in the country. Located in a major reception area for immigrants arriving in Toronto, LEF has developed a range of programs and services as part of its holistic approach. Its programs include skills training in sectors corresponding to local employment opportunities, language instruction and literacy classes for newcomers to Canada, 18 child care centres, 16 before- and after-school programs, a kitchen which prepares 500 meals a day for agencies serving the homeless, training enterprises in woodworking and food service

²⁵ <http://www.humandevdevelopmentcouncil.nb.ca/>

²⁶ <http://www.gnb.ca/cnb/promos/nptf/index-e.asp>

²⁷ <http://www.tnccdc.qc.ca/openfile.aspx?ID=196>

²⁸ <http://www.lescdcc.qc.ca/>

²⁹ <http://www.vsmsante.qc.ca/site/index.asp?sortcode=1.1>

for at risk youth, a recruitment service for employers, a technology help desk, computer access sites, a training loan fund, several social enterprises and self-employment training and support.³⁰

Manitoba's Neighbourhoods Alive! program is a long-term, community-based, social and economic development program that supports and encourages community-driven revitalization efforts focusing on key areas such as housing and physical improvements, employment and training, education and recreation, safety, and crime prevention.³¹ Through citizen-led Neighbourhood Renewal Corporations and a range of other programs, Neighbourhoods Alive! works with the strengths and experience of local residents to build healthy neighbourhoods.

Saskatoon's Quint Development Corporation was founded in 1995 to strengthen the economic and social well-being of Saskatoon's five core neighbourhoods through a community based approach. Community residents form at least three quarters of Quint's Board of Directors, and guide the organization's work to improve the availability of affordable housing, support business renewal and provide employment development opportunities.³² A major new business renewal initiative is Station 20 West, a community enterprise centre that will bring together under one roof a range of businesses, services and organizations – from a library and health and dental care to groceries and household tools. It is hoped that this community hub will serve as a catalyst for the economic and social renewal of Saskatoon's core neighbourhoods.

Another important model is the Healthy Communities movement. Growing out of an international conference on healthy public policy in Toronto in 1984, there are currently provincial Healthy Communities organizations in several provinces, including Ontario, Québec and BC. In British Columbia, the BC Healthy Communities (BCHC) engages governments and community organizations to link initiatives and programs interdepartmentally and intersectorally in order to address the multiple determinants of health. BCHC also uses community facilitation, workshops, tool kits and small seed grants to support communities and community groups taking a holistic and integrated approach to improving health and well-being.

An area of connectivity that merits particular consideration is the local role of the health care system. Witnesses before the Subcommittee and our own international comparative research have confirmed that the most effective health services are those that have a strong primary health care system, connected to a broader range of health and social services. Proactive prevention programs can also have a significant impact of improving health and well-being and enhancing productivity.

Local medical and public health officials can also take a leadership role in building public understanding about the links between health determinants and population health, and support the collaborative relationships needed at a local level to address the determinants of health. An outstanding example of this role can be found in the Saskatoon

The "H" needs to stand for "health care" more than "hospital". My message to you is that we do not have enough resources in the community. We have to shift into the community, away from the institutions.

Dr. Robert Cushman, Chief Executive Officer, Champlain Local Health Integration Network, 1 April 2009 (:).

³⁰ http://lefca.org/index.php?option=com_content&task=view&id=1

³¹ <http://www.gov.mb.ca/ia/programs/neighbourhoods/>

³² <http://www.quintsaskatoon.ca/aboutquint.html>

Health Region's 2008 report on health disparities.³³ The Saskatoon Health Region assembled shocking but solid evidence of health disparities in the city, and then carried out over 200 community consultations with various government representatives, academics and community groups on that evidence. The report proposes a comprehensive and coordinated set of evidence based policy options that gathered substantial support through an extensive international literature review, a second round of over 100 community consultations and a telephone survey of 5,000 Saskatoon residents.

Quebec's network of CLSCs (Centre local de services communautaires) and community health centres that can be found in other provinces demonstrate how neighbourhood centres can bring together a range of services located under one roof. Our examination of the polyclinic model in Cuba left no doubt about what can be accomplished with very limited budgets through a strong primary care presence, rooted in neighbourhoods, addressing many of the determinants of health simultaneously. Cuban polyclinics take a multidisciplinary approach, ensuring the integration of science, knowledge transfer, parent and grand-parent education and community mobilization as part of a strong multidisciplinary primary health system. As part of their prevention mandate, they regularly undertake universal screening initiatives and strongly encourage immunization. They also serve as a site for both medical training and education – students in medicine and nursing receive a great part of their training in polyclinics, often the one to which they will become professionally attached after graduation. As part of an integrated community approach, polyclinics work closely with teachers in early child development, preschool and elementary schools, holding regular meetings (every six months) to discuss the overall mental and physical health of the children in the community. Neighbourhood councils ensure that services such as early childhood education programs are connected to local needs.

The integration or coordination of services at the local level can help streamline and simplify access, increase efficiency, and bridge traditional program boundaries. But ultimately, integration is a process – there is no one model that can be applied in all situations. It is, rather, a goal that must be tailored to each individual community setting. What is important is an emphasis on collaborative responses focused on local needs.

Internationally, Canada is lagging behind other jurisdictions in this regard. We can learn from our own successful examples and those in other countries, notably Sweden and the United Kingdom, to find the optimal mix of top-down and bottom-up policy models, balancing local flexibility with national accountability. Therefore, the Subcommittee recommends:

That the Government of Canada work with other levels of government and the non-governmental sector to support the integration or coordination of community-level services within a determinant of health framework.

³³ http://www.saskatoonhealthregion.ca/your_health/documents/PHO/HealthDisparityRept-complete.pdf

4. ABORIGINAL POPULATION HEALTH

There is an enormous wealth of unrealized potential in Aboriginal communities whose development can be supported by the Government of Canada.³⁴

Currently, Aboriginal Canadians – First Nations, Inuit and Métis – all have a health status that is well below the national average. The evidence obtained by the Subcommittee shows that the Aboriginal experience in Canada is unequal. There are striking disparities between Aboriginal and non-Aboriginal Canadians in most health determinants and the gaps are widening. In particular, the socio-economic conditions in which Aboriginal peoples live are often cited as being similar to those in developing countries. This situation is not only deplorable, it is simply unacceptable.

Aboriginal peoples historically and to the present day have really not been full participants in the nation state called Canada. As the political economy of Canada evolved, it became necessary to dislocate Aboriginal peoples from their traditional lands and their way of life in order to make way for settler societies. That is not my opinion; it is a matter of fact. The process of dislocation as a result of colonization meant that many Aboriginal people and communities were socially excluded from Canada. This led to marginalization in education and employment, housing, health care and many other services. This, in turn, effectively created a two-tiered society in Canada – one standard for Canadians as a whole and another standard for Aboriginal peoples.

Jeff Reading, Professor and Director, Centre for Aboriginal Health Research, 26 March 2009 (3:12-13).

The Subcommittee recognizes the unique interests and specific needs of each Aboriginal group – First Nations, Inuit and Métis. We also concur with witnesses that this is inclusive of all Aboriginal peoples, who may reside on reserves or settlements, in rural or urban areas, or northern and arctic regions. The Subcommittee's approach to population health, with its focus at the community level, provides the flexibility to improve Aboriginal health and well-being while respecting social, cultural and local distinctions. We agree with witnesses who often stated that "One size definitely does not fit all." We also strongly concur with witnesses that even the most challenged and disadvantaged communities have significant and sometimes astonishing strengths, capacities and assets that can be used to enhance their physical and mental health and well-being. Aboriginal perspectives on health and well-being offer rich, holistic models. While First Nations, Inuit and Métis groups each presented their own vision and diagram of holistic wellness, these share many common elements with the framework we have illustrated in Chart 1 above. Because of the fundamental importance of respecting social, cultural and local distinctions in Aboriginal population health policies and programs, the Subcommittee recommends:

That Aboriginal peoples – First Nations, Inuit and Métis – be involved in the design, development and delivery of federal programs and services that address health determinants in their respective communities.

³⁴ Conference Board of Canada's Roundtable of the Socio-Economic Determinants of Health, *op. cit.*, p. 14.

The Subcommittee is aware that over 30 federal departments and agencies currently deliver some 360 federal programs and services to Aboriginal peoples and communities. These programs and services encompass health, lifelong learning, safe and sustainable communities, housing, economic opportunities, lands and resources, and governance relationships. The Subcommittee strongly agrees with numerous witnesses that these programs and services could be better coordinated and integrated with the view of addressing health determinants among the Aboriginal population. A whole-of-government approach, whereby the 30 departments and agencies work together in an integrated fashion, would be a first step in the reduction of health disparities between Aboriginal and non-Aboriginal Canadians. The current federal silos hinder Aboriginal communities from developing, at their own pace and according to their specific needs, a comprehensive approach to addressing the determinants of health. Breaking down these silos requires leadership from the top. Moreover, a population health approach is highly supportive of the Aboriginal belief that to be healthy one must achieve balance in all spheres – the spiritual, mental, emotional, physical and social.

In the Inuit world view, health, education and social conditions are all intertwined. It is a real challenge when you have departments that work pretty much in silos. (...) It is a real challenge for Inuit to work with a system that operates in silos.

Rosemary Cooper, Director of Executive Services, Inuit Tapiriit Kanatami, 25 March 2009 (2:41).

Witnesses told the Subcommittee that, following a formal apology to the “Stolen Generations” in 2008, the Australian Prime Minister took the lead in implementing “Closing the Gap on Indigenous Disadvantage.” The new approach rests on both new spending and redirected funding. Closing the Gap combines a whole-of-government approach at the Commonwealth level – the Indigenous Affairs Committee of Cabinet – with an intergovernmental mechanism – working in cooperation with the States and Territories – through the Council of Australian Governments (COAG). All six main targets related to Aboriginal life expectancy, mortality rate, literacy and numeracy, employment, schooling, and early childhood.

It has been a year since the Prime Minister in Australia issued a statement on closing the gap. In Australia, there is a national effort to close the gap between the health status for indigenous Australians versus the mainstream. On the first day of Parliament every working year, the Prime Minister reports to Parliament on the progress the entire government is making on closing the gap.

Jeff Reading, Professor and Director, Centre for Aboriginal Health Research, 26 March 2009 (3:31).

In Canada, the Prime Minister noted in his apology on behalf of all Canadians to residential school survivors that this was a new beginning and an opportunity to move forward together in partnerships. The Subcommittee believes that for the federal government, now is the time to act. Narrowing and ultimately eliminating the troubling disparities between Aboriginal and non-Aboriginal Canadians is essential to improving the health and socio-

In Canada, June 11 will be the first anniversary of our Parliament's apology to residential school survivors. The apology was not only about acknowledging the past but also about fundamental change. It is time to fundamentally change health systems and achieve real equity. My children and your children deserve nothing less.

Bob Watts, Chief Executive Officer, Assembly of First Nations, 25 March 2009 (2:32).

economic conditions of First Nations, Inuit and Métis. The approach adopted in Australia offers a very good model for Canada. Moreover, a number of pieces are already in place to move the agenda forward. In 2005, a process called the Canada-Aboriginal Peoples Roundtable resulted in a set of agreements between Aboriginal leaders and the Canadian governments, concerning standards of living and basic human rights. It set targets and allocated funding to reduce the disparities between Aboriginal communities and the general Canadian population. The degree of involvement of officials from the federal, provincial, and territorial governments, as well as Aboriginal leaders, communities, and organizations, was unique in Canadian history. The negotiations included: Inuit Tapiriit Kanatami (representing the Inuit); Métis National Council (representing the Métis); Assembly of First Nations (representing First Nations); Congress of Aboriginal People (representing urban and off-reserve Aboriginal peoples); Native Women's Association of Canada (representing Aboriginal women). The Subcommittee believes that Canada must build on this historical achievement and therefore, we recommend:

The Prime Minister noted in his apology on behalf of Canada to residential school survivors that this was a new beginning and an opportunity to move forward together in partnership. We are still waiting for movement. We believe that for the federal government, this is now the time to act.

Rose Sones, Assistant Director, Strategic Policy for Health and Social Affairs, Assembly of First Nations, 25 March 2009 (2:53).

That the Prime Minister of Canada, as a first step toward the development and implementation of a pan-Canadian population health strategy, work with provincial and territorial Premiers, as well as with First Nations, Inuit, Métis and other Aboriginal leaders in closing the gaps in health outcomes for Aboriginal Canadians through comprehensive, holistic, and coordinated programs and services.

That the following health determinants be given priority: clean water, food security, parenting and early childhood learning, education, housing, economic development, health care and violence against Aboriginal women, children and elders.

Numerous Aboriginal representatives told the Subcommittee how current jurisdictional disputes over program funding and delivery impede timely access to needed services and supports. In this context, they told us the story of Jordan River Anderson, a First Nation boy who was born with complex health needs. As his family did not have access to the supports needed to care for him at their home on reserve, they made the difficult decision to place him in child welfare care shortly after birth. Jordan remained in hospital for the first two years of his life as his medical condition stabilized. Shortly after Jordan's second birthday, doctors said he could go to a family home. However, federal and provincial governments disagreed on which government and department would pay for Jordan's at home care. The jurisdictional dispute lasted over two years during which time Jordan remained unnecessarily in hospital. Sadly, the boy passed away before the jurisdictional dispute was settled. In honoured memory of the boy, Jordan's principle was enunciated. This "child first" principle aims to ensure that necessary services for a child are not delayed or disrupted by jurisdictional disputes. In December 2007,

the federal government endorsed Jordan's principle when it adopted Private Member Motion 296. Implementing this historic child-first policy, however, requires support from all levels of government. Moreover, the Subcommittee agrees with witnesses that this principle should be extended to Aboriginal Canadians of all ages who "fall between the cracks" in the many areas where federal jurisdiction interacts with provincial and territorial responsibility. Therefore, the Subcommittee recommends:

That the Government of Canada work with all provincial and territorial governments to implement Jordan's principle for all programs, initiatives and services that address the health determinants of Aboriginal peoples in all age groups.

The Committee also heard repeatedly that the Aboriginal vision of physical and mental health and well-being is rooted in the medicine wheel and that it incorporates the importance of self-determination. Some witnesses suggested that the Cuban polyclinic model could be easily adapted in many Aboriginal communities to provide integrated population health services and programs. Others noted that the development of Aboriginal community councils with structures similar in some ways to that of regional health authorities would help support Aboriginal peoples' legitimate desire to achieve self-determination in the field of population health. Still, other witnesses indicated that some Aboriginal communities already have in place structures and mechanisms to facilitate the development and implementation of population health policy. Therefore, the Subcommittee recommends:

That the Government of Canada, in collaboration with its provincial and territorial counterparts, as well as the appropriate First Nations, Inuit and Métis organizations, support and fund appropriate structures and mechanisms across the country that will facilitate the development and implementation of comprehensive, holistic, and coordinated programs and services that address health disparities in Aboriginal communities.

CONCLUSION

Canada has led the world in understanding population health and health disparities. In 1974, the Lalonde report revolutionized thinking about health. This was further amplified in 1986 by the Ottawa Charter for Health Promotion and the Epp report. The Canadian Institute for Advanced Research, through its Population Health Program and such publications as *Why Are Some People Healthy and Others Are Not?*, has been seminal in understanding the determinants of health and health disparities. However, in recent years, as the costs and delivery of health care have dominated the public dialogue, there has been inadequate policy development reflecting what we have learned about population health. In fact, Canada has fallen behind countries such as the United Kingdom and Sweden in applying the population health knowledge base that has been largely developed here.

This lack of action has led to a widening of health disparities in Canada. The Subcommittee believes that it is unacceptable for a wealthy country like ours to continue to

tolerate such disparities in health. We fear that disparities may widen even further with the current economic crisis, which is unprecedented in terms of its global reach and impact. For these reasons, we propose a set of recommendations to foster health for all Canadians, and in particular our most disadvantaged groups – First Nations, Inuit and Métis peoples. Our focus on the life cycle, combined with a community-based approach, can lead to tremendous gains in health, productivity and wealth. This is possible if all governments act strategically and in a coordinated way on the determinants of health, mobilizing communities, the business sector and all Canadians behind a vision of a healthy, just and prosperous future. With the leadership of the Prime Minister of Canada, together we can achieve better health and wealth within a generation.

Senate



CANADA

Sénat

UN CANADA EN SANTÉ ET PRODUCTIF : UNE APPROCHE AXÉE SUR LES DÉTERMINANTS DE LA SANTÉ

**Comité sénatorial permanent des affaires sociales,
des sciences et de la technologie :
Rapport final du
Sous-comité sénatorial sur la santé des populations**

L'honorable Wilbert Joseph Keon, président
L'honorable Lucie Pépin, vice-présidente

Juin 2009

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This report is also available in English

LA SANTÉ EST EN GRANDE PARTIE DÉTERMINÉE PAR DES FACTEURS EXTÉRIEURS AU SYSTÈME DE SOINS DE SANTÉ

[L]e manque de soins sanitaires n'est pas à l'origine de la lourde charge mondiale de morbidité. Les maladies d'origine hydrique ne sont pas causées par une pénurie d'antibiotiques mais par l'eau polluée et par les forces politique, sociale et économique qui ont échoué à rendre l'eau propre disponible pour tous; la maladie cardiaque n'est pas causée par un manque d'unités de soins coronariens mais par la vie que les gens mènent, une vie modelée par l'environnement dans lequel ils vivent; l'obésité n'est pas causée par une fragilité morale chez les individus mais par l'existence à profusion d'aliments à forte teneur en lipides et en glucides. Ainsi, l'action principale sur les déterminants sociaux de la santé doit venir d'en dehors du secteur de la santé.

[Extrait de la Commission des déterminants sociaux de la santé de l'Organisation mondiale de la santé, Comblant le fossé en une génération : instaurer l'équité en santé en agissant sur les déterminants sociaux de la santé, 2008, p. 35.]

TABLE DES MATIÈRES

LISTE DES RECOMMANDATIONS.....	ii
ORDRE DE RENVOI.....	vii
MEMBRES.....	viii
LISTE D'ABRÉVIATIONS	ix
AVANT-PROPOS	1
INTRODUCTION	2
PARTIE I : LA SANTÉ DE LA POPULATION ET LES DISPARITÉS EN SANTÉ... 4	
1. LA SANTÉ DE LA POPULATION.....	4
2. DES SOINS DE SANTÉ AUX DÉTERMINANTS DE LA SANTÉ.....	7
3. L'AMPLEUR DES DISPARITÉS EN SANTÉ.....	9
4. LA NÉCESSITÉ D'AGIR, LE COÛT DE L'INACTION.....	16
PARTIE II : LA SANTÉ RAPPORTE – PASSONS À L'ACTION.....	17
1. UNE APPROCHE PANGOUVERNEMENTALE	17
1.1 Une question de gouvernance	18
1.2 La nécessité d'une vision.....	22
1.3 L'examen interministériel des dépenses	25
1.4 Une optique santé dans toutes les politiques	25
2. INFRASTRUCTURE DE BASE DE DONNÉES	28
2.1 Un système pancanadien de comptes communautaires	28
2.2 Recherche interventionnelle en santé des populations	32
3. METTRE LES COLLECTIVITÉS À CONTRIBUTION.....	34
3.1 Accroître les exigences en matière de rapports.....	35
3.2 Financement à plus long terme.....	36
3.3 Données et recherche sur les collectivités	36
3.4 Coordonner ou intégrer les services à l'échelon communautaire : modèles communautaires qui fonctionnent.....	38
4. LA SANTÉ DE LA POPULATION AUTOCHTONE	42
CONCLUSION	47
ANNEXE A	A1
ANNEXE B.....	B1
ANNEXE C	C1

LISTE DES RECOMMANDATIONS

1. **Que le premier ministre du Canada prenne les devants pour annoncer, élaborer et mettre en œuvre, à l'échelon fédéral, une politique sur la santé de la population;**

Qu'un comité du Cabinet sur la santé de la population soit créé et chargé de coordonner l'élaboration et la mise en œuvre de la politique fédérale sur la santé de la population;

Que le premier ministre du Canada préside le comité du Cabinet sur la santé de la population;

Que le comité du Cabinet sur la santé de la population soit composé des ministres compétents, notamment ceux qui dirigent les ministères et agences suivants : Ressources humaines et Développement des compétences, Affaires indiennes et du Nord canadien, Finances, Santé, Environnement, Justice, Agriculture et Agroalimentaire, Industrie, Agence de la santé publique et Condition féminine.

2. **Que le premier ministre du Canada convoque une réunion de tous les premiers ministres afin d'établir un mécanisme intergouvernemental de collaboration pour l'élaboration et la mise en œuvre d'une stratégie pancanadienne de santé de la population;**

Que les premiers ministres des provinces annoncent, élaborent et mettent en œuvre dans leur compétence respective une politique sur la santé de la population inspirée de la politique fédérale;

Que, dans chaque province et territoire, les premiers ministres mettent sur pied et président un comité du Cabinet sur la santé de la population.

3. **Que le Secrétariat du Conseil du Trésor prenne les devants et élargisse la gamme des modèles et des ressources disponibles en vue de la gestion de collaborations horizontales et verticales.**
4. **Que le gouvernement du Canada augmente le financement de l'Agence de la santé publique du Canada afin de créer un noyau de politiques et de connaissances qui servira de source d'information pour la mise en œuvre de politiques sur la santé de la population et la réduction des disparités en santé, tant à l'horizontale (à l'échelon fédéral) qu'à la verticale (collaboration intergouvernementale).**
5. **Que, dans la mesure du possible, les administrations locales ou municipales d'un bout à l'autre du pays adoptent et mettent en œuvre une vaste approche à l'égard de la santé de la population, au sein de**

leurs limites territoriales et en collaboration avec le gouvernement fédéral, les provinces et les territoires.

6. Que les Objectifs de santé pour le Canada adoptés en 2005 soient rétablis et orientent l'élaboration, la mise en œuvre et le suivi de la politique pancanadienne sur la santé de la population.
7. Que le Groupe d'experts sur la promotion de la santé de la population accélère ses travaux afin de terminer d'ici douze mois l'élaboration d'un ensemble national d'indicateurs des disparités en santé;

Que ces indicateurs des disparités en santé soient mis en rapport avec les Objectifs de santé pour le Canada.

8. Que le ministère des Finances, en collaboration avec le Bureau du Conseil privé et le Secrétariat du Conseil du Trésor, effectue un examen interministériel des dépenses en vue d'affecter les ressources aux programmes qui contribuent à réduire les disparités en santé.
9. Que le gouvernement du Canada exige la tenue d'une étude d'impact sur la santé pour tout projet de politiques, de plans ou de programmes soumis au Cabinet et susceptible d'avoir d'importantes répercussions sur la santé;

Que le Conseil privé, en collaboration avec Santé Canada, élabore des lignes directrices pour la mise en œuvre de la directive du Cabinet sur l'étude d'impact sur la santé;

Que les lignes directrices sur l'étude d'impact sur la santé soient élaborées au moyen des documents existants;

Que le gouvernement du Canada favorise le recours à l'étude d'impact sur la santé dans toutes les provinces et les territoires.

10. Que le gouvernement du Canada appuie l'élaboration et la mise en œuvre d'un programme de comptes communautaires, inspiré de celui de Terre-Neuve-et-Labrador, dans l'ensemble des provinces et territoires.
11. Que le développement, la gestion et le maintien de l'infrastructure de base de données pancanadienne sur la santé de la population soient confiés à l'Institut canadien d'information sur la santé;

Que l'ICIS entreprenne sans délai le travail d'intégration verticale des données nécessaire à cette fin, avec la collaboration des principaux partenaires.

12. Que Statistique Canada, en collaboration avec Inforoute Santé du Canada Inc., l'Institut canadien d'information sur la santé et d'autres

intervenants clés, élabore des normes pour faciliter le couplage de données entre les comptes communautaires et les Dossiers de santé électroniques sans pour autant compromettre la protection, la confidentialité et la sécurité des renseignements personnels;

Que l'élaboration des normes nécessaires à la protection, à la confidentialité et à la sécurité des renseignements personnels soit terminée d'ici les douze prochains mois.

13. Que les Instituts de recherche en santé du Canada (IRSC) travaillent en collaboration avec les ministères et organismes fédéraux compétents afin d'évaluer les investissements actuels dans la recherche interventionnelle en santé des populations et d'en arriver à un consensus sur ce que devrait être le niveau de financement dans ce domaine;

Que le gouvernement du Canada investisse davantage dans la recherche interventionnelle en santé des populations pour que le niveau de financement corresponde à celui convenu par les IRSC et les autres ministères et organismes compétents;

Qu'à l'avenir, la recherche interventionnelle en santé des populations financée par le gouvernement du Canada mise sur les capacités et les atouts des réseaux et des centres de recherche existants et encourage l'établissement de partenariats fondés sur la coopération entre les organismes de recherche municipaux, provinciaux et fédéraux ainsi qu'avec les milieux universitaires, en vue de la réalisation d'un programme de recherche ciblé;

Que le gouvernement du Canada mette au point des mécanismes de financement concurrentiels afin de mieux soutenir l'innovation et la recherche interventionnelle de pointe en santé des populations;

Que le gouvernement du Canada envisage l'adoption de mécanismes de financement conjoints pour soutenir les activités interprovinciales et internationales de recherche interventionnelle comparative en santé des populations;

Que le gouvernement du Canada examine les critères d'admissibilité au fonds pour l'infrastructure de recherche en santé humaine au Canada et essaie de voir comment ceux-ci pourraient mieux cadrer avec la recherche interventionnelle en santé des populations assortie de mécanismes de mise en œuvre dans le domaine de la santé et dans d'autres secteurs;

Que la recherche interventionnelle en santé des populations portant sur le logement, le développement de la petite enfance et l'atténuation

des effets de la pauvreté sur les Autochtones et les autres populations vulnérables soit considérée comme prioritaire.

14. Que le Secrétariat du Conseil du Trésor du Canada examine et revoit les exigences en matière de rapports sur les subventions et contributions imposées par les ministères et organismes fédéraux afin de mieux coordonner la production de rapports, tant à l'horizontale qu'à la verticale.
15. Que le Secrétariat du Conseil du Trésor du Canada favorise le financement sur plusieurs années des projets assortis d'échéanciers pluriannuels. De même, il faudrait encourager, le cas échéant, les organismes subventionnaires fédéraux à privilégier eux aussi un financement pluriannuel.
16. Que le gouvernement du Canada intègre le soutien de la capacité locale d'analyse et d'évaluation aux programmes visant à améliorer la santé de la population et à réduire les disparités en santé.
17. Que le gouvernement du Canada travaille en collaboration avec les autres ordres de gouvernement et le secteur non gouvernemental afin d'appuyer l'intégration ou la coordination de services communautaires dans un cadre de déterminants de la santé.
18. Que les peuples autochtones – Premières nations, Inuits et Métis – participent à la conception, à l'élaboration et à la prestation des programmes et des services fédéraux visant les déterminants de la santé dans leurs collectivités respectives.
19. Que le premier ministre du Canada, dans un premier pas vers l'élaboration et la mise en œuvre d'une stratégie sur la santé de la population pancanadienne, travaille de concert avec les premiers ministres des provinces et des territoires, ainsi qu'avec les dirigeants des Premières nations, des Inuits, des Métis et des autres peuples autochtones, afin de combler l'écart quant aux résultats en santé des Canadiens autochtones, au moyen de programmes et de services exhaustifs, holistiques et coordonnés.
20. Que la priorité soit accordée aux déterminants de la santé suivants : de l'eau propre, la salubrité des aliments, le rôle parental et l'apprentissage de la petite enfance, l'éducation, le logement, le développement économique, les soins de santé et la violence faite aux femmes, aux enfants et aux aînés autochtones.
21. Que le gouvernement du Canada s'entende avec les provinces et les territoires pour appliquer le principe de Jordan à tous les programmes, mesures et services portant sur les déterminants de la santé des Autochtones de tous les groupes d'âge.

22. Que le gouvernement du Canada, de concert avec ses homologues provinciaux et territoriaux ainsi qu'avec les organismes des Premières nations, inuits et métis compétents, appuie et finance la mise en place d'un bout à l'autre du pays des structures et mécanismes nécessaires pour faciliter l'élaboration et la mise en œuvre de programmes holistiques complets et coordonnés de nature à remédier aux disparités en santé dans les collectivités autochtones.

ORDRE DE RENVOI

Extrait des *Journaux du Sénat* du mardi 24 février 2009 :

L'honorable sénateur Eggleton, C.P., propose, appuyé par l'honorable sénateur Fraser,

Que le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie soit autorisé à examiner les divers facteurs et situations qui contribuent à la santé de la population canadienne, appelés collectivement les déterminants de la santé, entre autres les effets de ces déterminants sur les disparités et les inégalités sur le plan des résultats en santé auxquels sont exposés des groupes identifiables ou des catégories de personnes au Canada;

Que le comité examine les politiques, les programmes et les pratiques du gouvernement qui ont une incidence sur les déterminants de la santé et les résultats en santé dans les différents segments de la population canadienne, et qu'il s'informe des moyens que les gouvernements pourraient prendre pour mieux concerter leurs activités en vue d'améliorer les résultats en santé, que ces activités mettent à contribution les différents ordres de gouvernement ou divers ministères et services au sein d'un seul ordre de gouvernement;

Que le comité soit autorisé à étudier des exemples internationaux d'initiatives en matière de santé de la population prises par des pays en particulier ou par des organismes internationaux multilatéraux tels l'Organisation mondiale de la santé, sans toutefois s'y limiter;

Que les documents reçus, les témoignages entendus, et les travaux accomplis par le comité sur ce sujet au cours de la première session de la trente-neuvième législature soient renvoyés au comité;

Que le comité soumette son rapport final au plus tard le 30 juin 2009 et qu'il conserve tous les pouvoirs nécessaires pour diffuser ses conclusions dans les 180 jours suivant le dépôt du rapport final.

La motion, mise aux voix, est adoptée.

Le greffier du Sénat,

Paul C. Bélisle

MEMBRES

L'honorable Wilbert Joseph Keon, président du Comité

L'honorable Lucie Pépin, vice-présidente du Comité

Les honorables sénateurs :

Catherine S. Callbeck

Andrée Champagne, C.P.

Joan Cook

Nicole Eaton

Joyce Fairbairn, C.P.

Membres d'office du comité :

Les honorables sénateurs : James Cowan (ou Claudette Tardif) et Marjory LeBreton, C.P. (ou Gérald J. Comeau).

Autre sénateur ayant participé dans une large mesure à cette étude : L'honorable sénateur Eggleton, C.P.

Le comité remercie les membres du personnel suivants qui ont travaillé fort à la préparation du rapport.

Bibliothèque du Parlement :

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Michael Toye, conseiller

Direction des comités du Sénat :

Barbara Reynolds, greffière du Comité, 2^e session de la 39^e législature, 2^e session de la 40^e législature

Tracy Amendola, adjointe administrative, 2^e session de la 39^e législature

Keli Hogan, greffière du comité, 2^e session de la 40^e législature

Monique Régimbald, adjointe administrative, 2^e session de la 40^e législature

LISTE D'ABRÉVIATIONS

ASPC : Agence de la santé publique du Canada
BCHC: British Columbia Healthy Communities
CA : Community Accounts
CGA : Conseil des gouvernements d'Australie
CLSC : Centre local de services communautaires
CRSH : Conseil de recherches en sciences humaines
CRSNG : Conseil de recherches en sciences naturelles et en génie
DSE : dossier de santé électronique
EIE : évaluation d'impact sur l'environnement
EIS : étude d'impact sur la santé
F-P-T : fédéral-provincial-territorial
ICIS : Institut canadien d'information sur la santé
IRSC : Instituts de recherche en santé du Canada
LEF: Learning Enrichment Foundation
OCDE : Organisation de coopération et de développement économiques
OMS : Organisation mondiale de la santé
ONG : organisation non gouvernementale
R.-U. : Royaume-Uni
RMR : région métropolitaine de recensement
SFR : seuil de faible revenu

AVANT-PROPOS

Le Canada est généralement perçu comme l'un des meilleurs pays du monde où vivre. Son territoire est vaste, diversifié et riche en ressources naturelles et l'air qu'on y respire est de qualité. Pourtant, sur le plan de la santé, notre pays affiche malheureusement de graves disparités. Certains Canadiens sont en excellente santé toute leur vie et leur espérance de vie est parmi les plus élevées au monde; paradoxalement, d'autres sont en mauvaise santé toute leur vie et leur espérance de vie s'apparente à celle de certains pays du tiers monde. Les malheureux Canadiens qui sont en piètre santé toute leur vie sont souvent moins productifs et ajoutent au fardeau du système de soins de santé et au filet de sécurité sociale. Notre système de santé ne peut à lui seul remédier à ces inégalités, peu importe l'argent que nous y investissons.

Il faut changer notre façon de penser et reconnaître qu'une bonne santé dépend de divers facteurs et influences, dont 75 p. 100 n'ont aucun rapport avec le système de soins de santé. Il faut donc agir de façon proactive et aider les collectivités, les villes, les provinces, les territoires et le pays à produire des citoyens en bonne santé, à assurer leur mieux-être physique et mental et à préserver leur productivité. Attendre passivement que la maladie se déclare et essayer ensuite d'y trouver un remède grâce au système de soins de santé n'est tout simplement pas une option. Nous devons donc prendre en considération tous les facteurs qui influencent la santé et, grâce à une approche axée sur la santé de la population, remédier aux inégalités et contribuer au mieux-être et à la productivité.

Les connaissances et les technologies nécessaires à cette fin sont maintenant à portée de main, mais des recherches plus poussées s'imposent. Tout changement exigera une mobilisation de la part de l'ensemble des particuliers, des ONG, des entreprises, des collectivités, des ordres de gouvernement et des différents secteurs de la société canadienne. L'entreprise ne pourra être menée à bien que si notre premier ministre et nos premiers ministres provinciaux, nos maires, nos dirigeants municipaux et communautaires ainsi que les chefs des Premières nations exercent un leadership. Il faudra adopter une approche pangouvernementale axée sur une intervention intersectorielle reposant sur la participation des entreprises, des bénévoles et des organismes communautaires. La tâche ne sera pas facile, mais elle peut et doit être accomplie. Nous ne pouvons nous y soustraire.

Nous devons mettre en place un système d'information sur la santé de la population doté d'une capacité longitudinale, qui permette de suivre et d'évaluer le bien-être tout au long du parcours de vie humain, puis d'en faire rapport. L'intervention communautaire doit quant à elle miser sur l'éducation et mettre à contribution les services de santé et les services sociaux, de façon à réduire les disparités en santé, à contrer la prévalence de la maladie et à accroître la productivité. Cette tâche ne doit pas nous rebuter, puisqu'elle est réalisable et qu'elle contribuera à long terme à l'égalité en santé et au mieux-être de la population et améliorera radicalement notre productivité globale. Chaque Canadien doit relever le défi au bénéfice de tous.

INTRODUCTION

Instaurer l'équité en santé en l'espace d'une génération; il le faut et c'est maintenant qu'il faut agir¹.

Avec le dépôt de ce rapport final, le Sous-comité sur la santé des populations du Comité sénatorial permanent des affaires sociales, des sciences et de la technologie arrive au terme d'un long parcours, qui s'est amorcé en février 2007, au cours de la première session de la 39^e législature, lorsque le Sous-comité a reçu du Sénat le mandat d'« examiner les divers facteurs et situations qui contribuent à la santé de la population canadienne, appelés collectivement les déterminants de la santé ». Ce mandat a été reconduit deux fois, soit en octobre 2007, au début de la deuxième session de la 39^e législature, puis en février 2009, au début de la deuxième session de la 40^e législature.

Le présent rapport est donc l'aboutissement d'une étude à laquelle le Sous-comité a consacré deux années complètes. Au cours de cette période, le Sous-comité a siégé pendant 52 heures, tenu 30 séances, entendu au-delà de 117 témoins et reçu des centaines de mémoires. Les membres ont aussi visité six collectivités canadiennes et effectué une mission d'étude à l'étranger. Nous tenons à remercier sincèrement tous ceux qui nous ont donné leur avis sur les mesures à prendre pour améliorer la santé des Canadiens, réduire les disparités en santé et accroître la productivité du Canada. Nous avons examiné attentivement leurs observations et leurs propositions et les avons trouvées particulièrement à propos dans le contexte actuel de ralentissement économique.

Notre rapport final a été précédé de quatre rapports provisoires :

- *Politiques sur la santé de la population : Perspective internationale* présente une analyse des politiques gouvernementales destinées à promouvoir la santé de la population et à réduire les disparités en matière de santé en Australie, en Angleterre, en Finlande, en Nouvelle-Zélande, en Norvège et en Suède.
- *La santé maternelle et le développement de la petite enfance à Cuba* résume les observations du Sous-comité quant au contenu, à la structure, au coût, à la gestion et à l'incidence des programmes de santé maternelle et des projets de développement de la petite enfance à Cuba. L'efficacité de l'approche cubaine en matière de santé maternelle et de développement de la petite enfance repose en grande partie sur ce que les Cubains appellent la « polyclinique ». Ce genre d'établissement joue un rôle beaucoup plus grand que celui de la clinique de santé telle que la conçoivent les Canadiens, puisqu'il assure l'intégration de la science, le transfert des connaissances, l'éducation des parents et la mobilisation de la collectivité, et donne ainsi une solide dimension multidisciplinaire au secteur des soins de santé primaires.
- *Politiques sur la santé de la population : Perspectives fédérale, provinciale et territoriale* décrit les efforts déployés par le gouvernement fédéral de même que par les provinces et

¹ Commission des déterminants sociaux de la santé de l'Organisation mondiale de la santé, *Comblant le fossé en une génération : instaurer l'équité en santé en agissant sur les déterminants sociaux de la santé*, 2008, http://whqlibdoc.who.int/publications/2009/9789242563702_fre.pdf.

territoires pour élaborer et mettre en œuvre des politiques sur la santé au Canada. L'administration fédérale ainsi que les provinces et territoires ont consacré beaucoup d'énergie à la santé de la population au cours des 35 dernières années. Pourtant, le Canada n'a toujours pas de plan national pour réduire les disparités en santé et améliorer la santé de sa population en général.

- *Politiques sur la santé de la population : enjeux et options* énonce les grands enjeux liés à l'élaboration de politiques sur la santé de la population au Canada et présente des options de politiques à adopter pour améliorer la santé en général et réduire les disparités sur le plan de la santé.

Ces rapports ont permis de lancer un débat public sur le rôle des gouvernements, en particulier du gouvernement fédéral, dans l'élaboration et la mise en œuvre d'une approche axée sur les déterminants de la santé au Canada. Ils ont aussi été le point de départ d'audiences et de consultations publiques tenues avec des Canadiens provenant de tous les coins du pays. Le présent rapport final, qui est l'aboutissement de ce processus de consultation, met fin à l'étude du Sous-comité. Les recommandations qui y sont formulées peuvent être regroupées en quatre catégories :

- Un nouveau style de gouvernance : une direction de la part des instances décisionnelles supérieures pour élaborer et mettre en œuvre une politique sur la santé de la population à l'échelle fédérale, provinciale, territoriale et locale, assortie d'objectifs clairs, et une optique santé à l'égard de toutes les nouvelles politiques et de tous les nouveaux programmes.
- Le fondement : une infrastructure de base de données fiables sur la santé de la population coordonnée par l'Institut canadien d'information sur la santé, inspirée du modèle des comptes communautaires (Community Accounts) de Terre-Neuve-et-Labrador et assortie des liens nécessaires pour permettre un couplage avec les dossiers de santé électroniques. Statistique Canada et les intervenants compétents élaboreront des normes afin d'assurer la protection, la confidentialité et la sécurité des renseignements personnels. Cette infrastructure de base de données s'accompagnera d'une solide recherche interventionnelle en santé des populations de façon à pouvoir prendre des décisions éclairées en matière de politique gouvernementale.
- Bâtir des collectivités saines : parce que les déterminants de la santé se jouent à l'échelon local, les gouvernements doivent miser sur l'expertise des citoyens et chercher à renforcer leur capacité de doter leurs collectivités de la force et de l'ouverture voulues pour que la population soit en santé et productive. Le modèle cubain de polyclinique offre d'intéressantes possibilités de collaboration intersectorielle à l'échelon local et pourrait être adapté dans certaines collectivités canadiennes.
- L'élaboration et la mise en œuvre d'une politique pancanadienne sur la santé de la population et la réduction des disparités en santé doivent viser en priorité les Premières nations, les Inuits et les Métis; une collaboration doit s'établir avec les dirigeants en place pour répondre aux besoins actuels; les particularités culturelles doivent être valorisées et les perspectives d'avenir élargies.

Le Sous-comité croit que le moment est vraiment propice pour mettre en œuvre ses recommandations. Les appuis sont nombreux de la part des représentants du milieu des affaires, des collectivités rurales, urbaines et autochtones, des organismes non gouvernementaux, des instituts de recherche, des universités, des associations professionnelles, des régies de la santé, des instances gouvernementales, etc. Il y a en outre un mouvement favorable au niveau national et international depuis la publication des recommandations fondées sur des preuves de l'Organisation mondiale de la santé (OMS) dans le rapport final de la Commission sur les déterminants sociaux de la santé, du premier rapport de l'administrateur en chef de la santé publique du Canada et des résultats de la table ronde du Conference Board du Canada sur les déterminants sociaux de la santé, entres autres documents. Bien d'autres pays – comme l'Angleterre, la Finlande, la Norvège et la Suède – et un certain nombre de provinces – notamment Terre-Neuve-et-Labrador et Québec – ont pris les devants et mis en place des mesures et des programmes pour réduire les disparités en santé. C'est pourquoi nous sommes fermement convaincus que le moment est venu pour le gouvernement fédéral et les autres ordres de gouvernement d'agir en ce qui concerne les déterminants de la santé au Canada. En fait, il n'est pas exagéré d'affirmer qu'aucune société ne peut renverser le ralentissement économique actuel et contribuer ensuite au progrès économique, si elle néglige la santé de sa population. Si nous n'agissons pas, les disparités en santé au Canada, qui sont déjà importantes, risquent de s'aggraver encore, au point de compromettre notre prospérité économique future.

PARTIE I : LA SANTÉ DE LA POPULATION ET LES DISPARITÉS EN SANTÉ²

1. LA SANTÉ DE LA POPULATION

Notre étude des déterminants de la santé repose sur les notions de santé et de santé de la population. Le Sous-comité a adopté la définition de l'OMS, qui est bien connue et qui décrit la **santé** comme « un état de complet bien-être physique, mental et social » et « une ressource au quotidien³ ». De ce point de vue, une bonne santé contribue de façon importante au développement social, économique et personnel et elle joue pour beaucoup dans la qualité de vie. Le corollaire est tout

[...] [J]e crois que le problème de la santé de la population ne porte pas uniquement sur la santé, mais sur la population. C'est très général.

Jean-Marie Berthelot, vice-président, Programmes, Institut canadien d'information sur la santé, 27 mars 2009 (3:74).

aussi vrai, puisque la notion de **santé de la population** part du principe que la santé est beaucoup plus tributaire de facteurs socioéconomiques, environnementaux et culturels que de facteurs génétiques ou médicaux. Ainsi, des facteurs comme le revenu, le niveau de scolarité, l'emploi, la hiérarchie sociale et le logement, qui sont tous des **déterminants de la santé**, ont une incidence directe ou indirecte sur la santé et le bien-être de la population. Bon nombre d'entre eux ont une incidence déterminante dans les collectivités canadiennes – les villes, les villages, les quartiers et les régions où les gens vivent, apprennent, travaillent et se divertissent. C'est pourquoi l'approche adoptée par le Sous-comité à l'égard de la santé de la population met l'accent sur le

² Dans le présent rapport, les renvois aux témoignages reproduits dans les *Procès-verbaux et les Témoignages du Sous-comité sur la santé des populations du Comité sénatorial permanent des affaires sociales, des sciences et de la technologie* seront ci-après indiqués uniquement par le numéro de fascicule et le numéro de page.

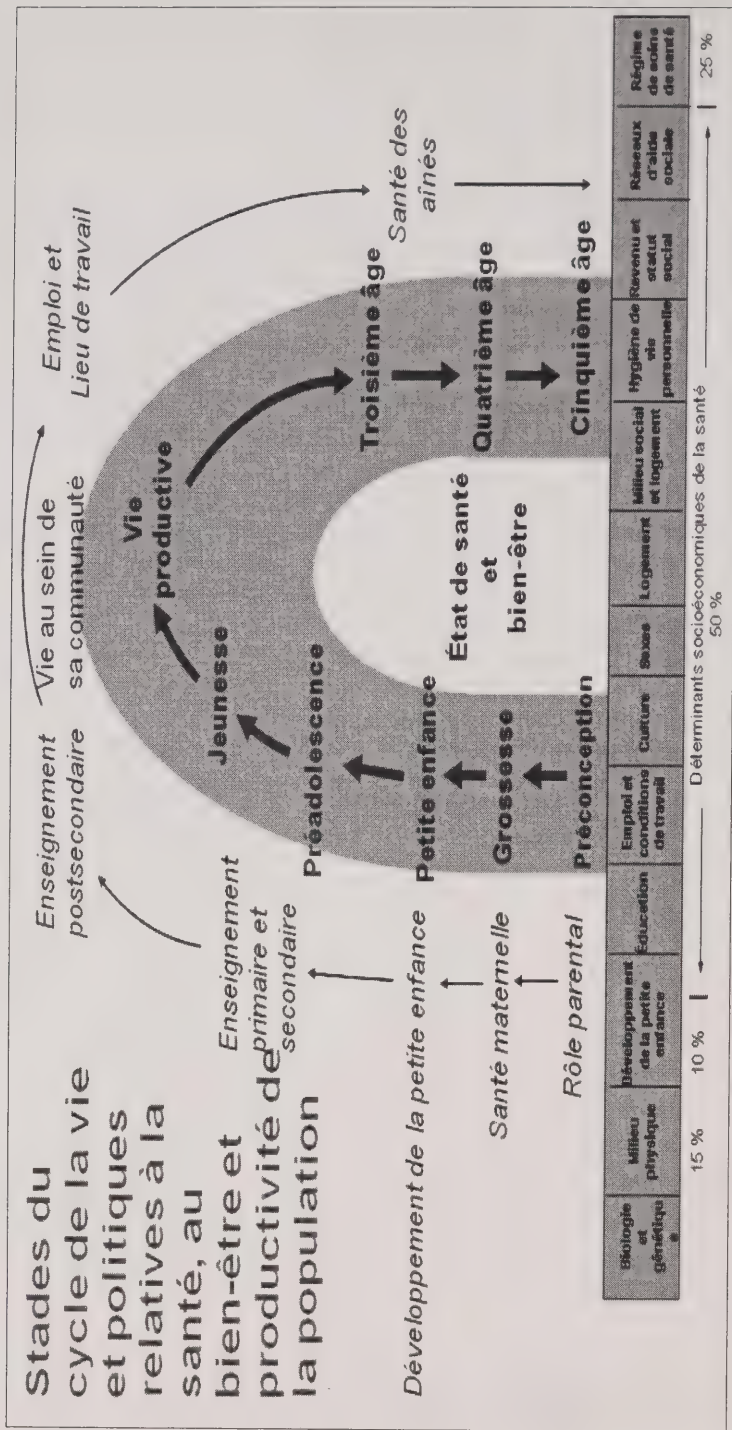
³ Organisation mondiale de la santé, <http://www.who.int/fr/>.

contexte communautaire. Par ailleurs, comme les effets des déterminants de la santé varient selon les différentes périodes de la vie d'une personne, notre approche s'inscrit dans une **optique de durée de vie** – c'est-à-dire qu'elle tient compte des facteurs qui peuvent influencer la santé d'une personne dès avant sa naissance jusqu'à l'âge adulte, en passant par l'enfance et l'adolescence. L'approche axée sur les déterminants de la santé que propose le Sous-comité est illustrée au graphique 1.

La combinaison et l'interaction des déterminants de la santé influent de diverses façons sur l'état de santé; ces différences créent à leur tour des **disparités en santé** d'une personne ou d'un segment de la population à l'autre. Il est largement reconnu à l'échelle nationale et internationale que la grande majorité des disparités en santé sont évitables, injustes et, par conséquent, inévitables. Ces inégalités sur le plan de la santé sont imputables à l'environnement extérieur et à d'autres conditions sociales et économiques sur lesquelles les principaux intéressés ont fort peu de prise, mais qui peuvent être améliorées grâce à la mise en œuvre d'une politique gouvernementale bien conçue que nous appelons ici la **politique sur la santé de la population**.

La politique sur la santé de la population est, de par sa nature, intersectorielle – c'est-à-dire qu'elle est conçue pour tenir compte de façon coordonnée de tout l'éventail des déterminants qui influent sur la santé. Ce genre de **collaboration intersectorielle** revêt deux dimensions : l'une horizontale et l'autre verticale. La dimension horizontale fait intervenir différents secteurs, comme l'éducation, les finances, l'emploi, les services sociaux, l'environnement, la santé, etc. À l'intérieur d'une même administration, une telle approche est dite « interministérielle » ou « pangouvernementale ». La dimension verticale suppose une concertation de secteurs d'intervention à différents échelons gouvernementaux; par exemple, les gouvernements fédéraux, provinciaux/territoriaux, régionaux et locaux ou municipaux s'allient à des groupes, des institutions, des organismes et des entreprises de la collectivité. L'intervention intersectorielle est fructueuse lorsque tous les participants à chaque échelon en sortent gagnants.

GRAPHIQUE 1



Source : Service d'information et de recherche parlementaires, Bibliothèque du Parlement.

Les membres du Sous-comité croient qu'il y a définitivement une demande en matière de santé de la population au Canada, mais que celle-ci n'est pas étiquetée comme telle. Les partisans de la lutte à la pauvreté, à l'exclusion et à la dégradation de l'environnement, tout comme les défenseurs de la condition féminine, des logements sociaux, de l'accès à une eau potable de qualité et de la justice sociale de façon générale, sont tous favorables à une intervention pour réduire les disparités et améliorer la santé de façon que les Canadiens puissent s'épanouir, vivre et contribuer pleinement à la société. Malheureusement, il n'existe pas de terminologie simple ou unique pour parler de ces questions. Le Sous-comité, à l'instar des spécialistes en santé publique et en promotion de la santé, utilise les expressions *santé de la population*, *bien-être* et *inégalités en matière de santé*, tandis que les économistes et les gens d'affaires préfèrent parler de *capital humain*. Pour leur part, les sociologues et les biologistes estiment que cet enjeu en est un de *développement humain*, tandis que les environnementalistes l'associent plutôt à la *viabilité de l'environnement*. Pour les Autochtones, c'est la *santé holistique* et le *bien-être* qui est en cause. Peu importe la façon de le formuler, l'objectif ultime du présent rapport est de faire en sorte que la population – sa santé physique et mentale, son bien-être et sa qualité de vie – soit au cœur des politiques gouvernementales. C'est ce que le Sous-comité recommande lorsqu'il prend position en faveur d'une approche axée sur les déterminants de la santé au Canada.

L'exigence existe peut-être, mais elle est fragmentée et, à mon avis, impossible à cerner pour le pouvoir politique en ce moment.

*L'honorable Monique Bégin,
18 avril 2008 (4:104).*

En fait, qu'on parle d'économie, de sécurité du revenu ou d'environnement, on en revient toujours à la santé de la population.

*Mel Cappe, président, Institut de recherche en politiques publiques,
26 février 2009 (1:15).*

2. DES SOINS DE SANTÉ AUX DÉTERMINANTS DE LA SANTÉ

Comme il est mentionné précédemment, les déterminants de la santé sont constitués de facteurs personnels, culturels, socioéconomiques et environnementaux. Le graphique 1 – et les exemples recensés dans les ouvrages canadiens – donne à penser que le système de **soins de santé** contribue à la santé de la population, mais son apport à cet égard ne représente que 25 p. 100, quel que soit le niveau de financement auquel il a droit. Trop souvent, le système de soins de santé réagit après coup, c'est-à-dire une fois que la maladie (dans bien des cas, évitable) s'est déclarée. Il est clair que la santé ne dépend pas seulement des soins de santé et, de tous les déterminants de la santé, le contexte socioéconomique est celui qui a le plus d'impact. L'adoption d'une approche active plutôt que passive à l'égard de la santé et l'idée d'intervenir avant que la maladie ne se déclare sont donc d'autant plus justifiées.

La biologie fondamentale et la constitution organique de l'être humain sont des déterminants fondamentaux qui influent sur la santé d'une personne dans une proportion de 15 p. 100. Dans certains cas, le **patrimoine génétique** semble prédisposer certains individus à certaines maladies ou à des problèmes de santé particuliers.

Le **logement** ou le manque de logement adéquat (surpeuplement, habitations insalubres, maisons exigeant d'importantes réparations, sans-abrisme, etc.) contribue à l'augmentation du stress, de la morbidité, de la mortalité, de l'exclusion sociale et de la maladie physique et

mentale. Inutile de dire que la santé est d'abord tributaire de la qualité du logement; par conséquent, la promotion de la santé de la population passe d'abord par l'accès à un logement sain et abordable. D'autres éléments de notre **environnement physique** qui sont le fait de l'homme, comme un milieu de travail et des collectivités sûrs, des villes bien aménagées, de bonnes routes, etc., sont essentiels à la santé de la population, au même titre que la qualité de l'air, de l'eau et du sol. Dans l'ensemble, 10 p. 100 des résultats en santé sont attribuables à l'environnement physique.

La santé de la population dépend de facteurs socioéconomiques dans une proportion d'au moins 50 p. 100. Les déterminants socioéconomiques de la santé sont complexes et inextricablement liés les uns aux autres. Nous en décrivons quelques-uns ci-dessous.

Le **développement de la petite enfance**, de la préconception à la grossesse en passant par le rôle parental tout au long des premières années de vie, est souvent considéré comme un puissant déterminant de la santé et un élément charnière de l'adoption à l'égard de la santé de la population d'une approche qui tient compte de toutes les étapes de la vie. Il est démontré scientifiquement que les expériences vécues entre la conception et la sixième année de vie sont déterminantes dans le cycle de vie en ce qui a trait au développement et à la conduction des neurones du cerveau de l'enfant. Les stimulations positives dans l'enfance améliorent la santé, le mieux-être et la capacité d'adaptation pendant tout le reste de la vie.

L'**éducation** est étroitement liée à la situation socioéconomique et une éducation efficace des enfants ainsi que l'éducation permanente pour les adultes sont autant d'éléments qui contribuent au premier chef à la santé et à la prospérité des individus et du pays. Le niveau d'instruction contribue à la santé et à la prospérité en donnant aux gens les connaissances et les capacités dont ils ont besoin pour résoudre des problèmes et leur procure aussi le sentiment de contrôler leur propre vie. Les gens plus instruits ont plus de possibilités d'emploi, une meilleure sécurité du revenu et une plus grande satisfaction au travail. Il leur est aussi plus facile de se renseigner et de comprendre comment faire pour prendre soin de leur santé. La responsabilité individuelle à l'égard de sa santé est un autre élément important d'une approche holistique et pangouvernementale à l'égard de la santé de la population.

L'existence d'un lien entre le **revenu et le statut social** et la santé est de plus en plus étayée et les preuves à cet égard sont probantes. Encore plus évident, la santé des gens varie en fonction des différences de revenu entre les plus riches et les plus pauvres de notre société. Les personnes à faible revenu et au statut social plus modeste ont moins de contrôle sur leur vie et moins de choix, et cette situation empire lorsque l'écart des revenus dans une société est très marqué.

Il est démontré que l'**emploi et les conditions de travail** ont une importante incidence sur la santé physique et mentale ainsi que sur le mieux-être social d'une personne. Le revenu gagné procure non seulement de l'argent, mais aussi un sentiment d'identité et d'utilité, des contacts sociaux et des occasions de croissance personnelle. Quand une personne perd ces avantages, les résultats peuvent être dévastateurs, aussi bien pour sa santé que pour celle des membres de sa famille.

Enfin, le Sous-comité a recueilli des témoignages concernant l'impact de la **culture** et du **sexe** sur la santé. La race, l'ethnicité ou le bagage culturel peuvent influencer sur la santé de la population en rendant les gens plus ou moins vulnérables aux risques auxquels ils sont collectivement exposés. De même, les différents rôles, traits de personnalité et pouvoirs relatifs attribués par la société selon que l'on est un homme ou une femme peuvent tous influencer sur la santé. Une approche sexospécifique à l'égard de la santé de la population permet de tenir compte des différences entre les femmes et les hommes, de voir en quoi les risques pour la santé, les expériences et les résultats sont influencés différemment selon que l'on est une femme ou un homme, une fille ou un garçon, et d'intervenir en conséquence. De plus, l'approche adoptée à l'égard de la santé de la population doit être culturellement adaptée et suffisamment souple pour prendre en compte les besoins particuliers des différents groupes culturels et ethniques qui forment notre pays.

3. L'AMPLEUR DES DISPARITÉS EN SANTÉ

Certains Canadiens sont beaucoup plus en santé que d'autres. Les problèmes de santé sont beaucoup plus fréquents chez les enfants et les familles qui vivent dans la pauvreté; les gagne-petit; les chômeurs/sous-employés; les personnes peu scolarisées et/ou peu alphabétisées; les Autochtones et les populations des régions éloignées; les nouveaux arrivants; les personnes victimes d'exclusion sociale; les sans-abri et les personnes qui ont de la difficulté à trouver un logement abordable⁴.

Tout au long de son étude, le Sous-comité a recueilli des témoignages convaincants au sujet de l'ampleur des disparités en santé. Il y a au Canada de vastes disparités entre les hommes et les femmes, d'une région ou d'un quartier à l'autre ainsi que selon le niveau de scolarité et de revenu. Même si le nombre de personnes en mauvaise santé se répartit sur l'ensemble de la population, il est disproportionnellement élevé dans certains groupes, comme chez les Autochtones ou chez les personnes et les familles à faible revenu.

Comme l'indique le tableau 1, la différence entre l'état de santé des Canadiens en général et celui des populations autochtones – Premières nations, Inuits et Métis – est frappante. Par exemple, la durée de vie moyenne des femmes inuites est inférieure de 12 ans à celle des femmes canadiennes, tandis que l'écart pour les hommes est de 8 ans. Le tableau 1 montre aussi que la situation socioéconomique de chacun des groupes autochtones est moins reluisante que chez le reste de la population canadienne à pratiquement tous les égards. Le niveau de scolarisation est moins élevé, le chômage est plus élevé et le revenu moyen est plus faible. Il y a beaucoup plus de fumeurs chez les Autochtones que dans le reste de la population. Jeff Reading, professeur et directeur du Centre for Aboriginal Health Research, à l'Université de Victoria, a préparé pour le Sous-comité un document où il présente une série de données des plus complètes sur le fardeau économique de la maladie et l'ampleur des disparités en santé chez les Premières nations, les Inuits et les Métis. Dans son document, il reconnaît que les piètres conditions de vie des Autochtones contribuent à leur mauvais état de santé par rapport au reste de la population

⁴ BC Healthy Living Alliance, *Mémoire au Sous-comité*, 8 juin 2008, p. 2.

canadienne. Ces piètres conditions ne sont pas étrangères au processus de dislocation qui a fait suite à la colonisation et qui a entraîné l'exclusion sociale des populations et des collectivités autochtones du reste du Canada⁵.

TABLEAU 1
INÉGALITÉS OBSERVÉES DANS LES DÉTERMINANTS DE LA SANTÉ :
BEAUCOUP DE TRAVAIL RESTE À FAIRE POUR AMÉLIORER L'ÉTAT DE SANTÉ
DES POPULATIONS AUTOCHTONES

	Non- Autochtones	Premières nations	Inuits	Métis
État de santé				
Espérance de vie à la naissance (hommes)	76	69	68	n.d.
Espérance de vie à la naissance (femmes)	82	77	70	n.d.
Éducation (% 15 ans et plus)				
Aucun grade, diplôme ou certificat	33	55	66	46
Baccalauréat	16	4,1	1,9	5,3
Emploi (% 15 ans et plus)				
Taux de chômage	7	22	22	14
A travaillé toute l'année à temps plein	37	23	23	31
Revenu (% 15 ans et plus)				
Faible revenu en 2000	16	40	24	28
Mode de vie (% de la population)				
Consommation quotidienne de cigarettes	22	38	61	37

n.d. : non disponible

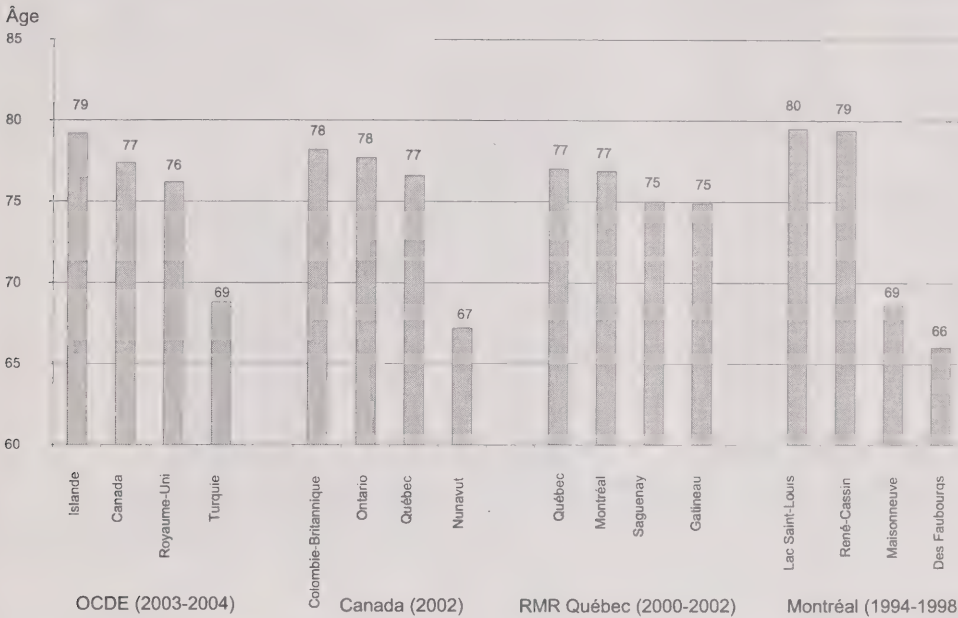
Source : Initiative sur la santé de la population canadienne, Améliorer la santé des Canadiens, 2004, http://securite.cihi.ca/cihiweb/products/IHC2004rev_f.pdf.

Le Sous-comité s'est aussi fait dire à maintes reprises qu'il existait des disparités en santé d'un pays à l'autre et à l'intérieur d'un même pays. Par exemple, le graphique 2 montre que l'espérance de vie au Canada est l'une des plus élevées au monde. Ce ne sont cependant pas tous les Canadiens qui ont une longue espérance de vie. D'un bout à l'autre du pays, l'écart à cet égard est de 11 ans, le Nunavut ayant la plus faible espérance de vie à 67 ans et la Colombie-Britannique la plus longue, à 78 ans. Il y a en outre des différences à l'intérieur d'une même province. Au Québec, par exemple, l'espérance de vie n'est pas la même à Montréal et à Gatineau. Lorsqu'on regarde la situation à plus petite échelle encore, les recherches effectuées par le Service de santé publique de Montréal montrent que d'un quartier à l'autre de la ville,

⁵ Jeff Reading, « *A Life Course Approach to the Social Determinants of Health for Aboriginal Peoples* », 30 mars 2009.

l'espérance de vie peut varier de 14 ans. Ces observations font ressortir la nécessité d'adopter une approche communautaire en matière de santé de la population.

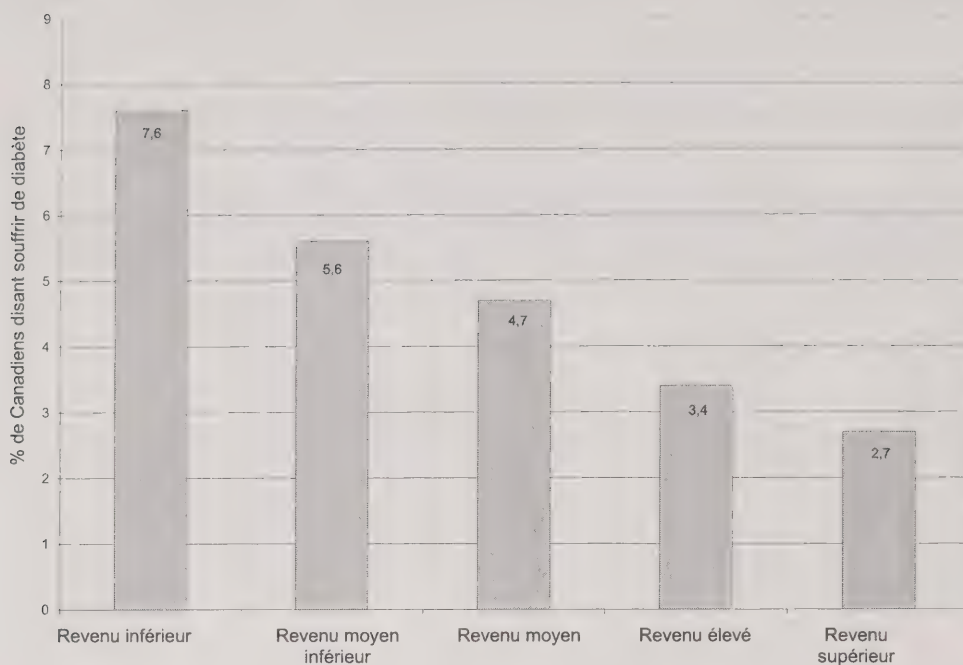
**GRAPHIQUE 2 : L'ENDROIT OÙ L'ON VIT
A UNE INCIDENCE SUR LA SANTÉ
DIFFÉRENCES DANS L'ESPÉRANCE DE VIE À LA NAISSANCE, HOMMES**



Source : Reproduit à partir de Glenda Yeates, « Disparités sur le plan de la santé au Canada », Mémoire au Sous-comité, 18 avril 2008.

Le graphique 3 montre que la prévalence de la maladie – dans ce cas particulier, le diabète – diminue progressivement à mesure que le niveau de revenu augmente. Autrement dit, l'état de santé s'améliore graduellement à mesure que le revenu progresse. La présence de ce gradient en santé n'est pas unique au Canada; elle a été démontrée ailleurs au Canada et à l'étranger, de même qu'au niveau des municipalités, des quartiers et des régions. Toutefois, le niveau et le degré de la pente du gradient ne sont pas uniformes d'un endroit à l'autre. Dans les pays industrialisés, le gradient est plus marqué dans des pays comme les États-Unis, mais il l'est moins dans des pays comme la Norvège et la Suède.

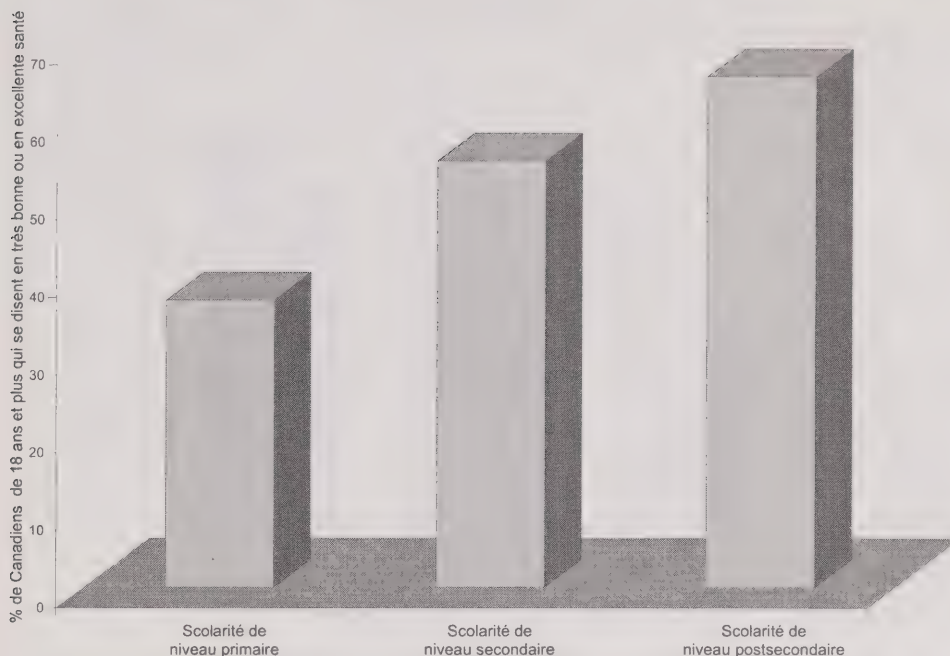
GRAPHIQUE 3 : LE GRADIENT SOCIOÉCONOMIQUE EN SANTÉ



Source : Statistique Canada, Enquête sur la santé des collectivités canadiennes (Cycle 3.1), 2005; Service d'information et de recherche parlementaires, Bibliothèque du Parlement.

L'Enquête sur la santé des collectivités canadiennes de 2005 révèle que les Canadiens vivant dans des ménages où le niveau de scolarité est inférieur sont moins nombreux à se déclarer en excellente ou en très bonne santé. Il est clair, à la lumière du gradient en santé illustré au graphique 4, que plus le niveau de scolarité est élevé, plus la proportion de personnes se disant en excellente ou en très bonne santé augmente.

GRAPHIQUE 4 : L'ÉDUCATION EST UN FORT DÉTERMINANT DE LA SANTÉ



Sources : Statistique Canada, Enquête sur la santé des collectivités canadiennes (Cycle 3.1), 2005; Service d'information et de recherche parlementaires.

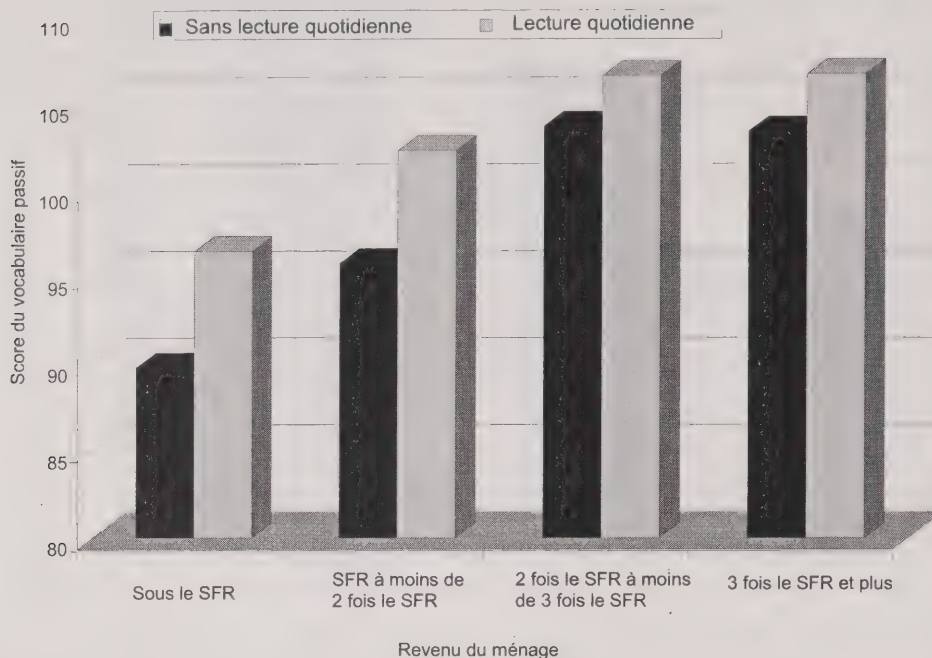
De nombreux témoins ont insisté sur l'importance de remédier aux disparités en santé le plus vite possible. Le graphique 5 montre que le gradient en santé se manifeste dès les premières années de vie. Il montre aussi que la participation parentale à l'éducation préscolaire des enfants influe sur leur succès sans égard au niveau de revenu. Pour chaque niveau de revenu du ménage, les enfants à qui on fait la lecture tous les jours ont de meilleurs scores du vocabulaire passif que ceux à qui on ne fait pas la lecture tous les jours. Ce sont là des observations très cruciales, étant donné que le capital humain à l'âge adulte est déjà en grande partie déterminé dès l'enfance. De façon plus précise, les mesures du développement de l'enfant, comme son habilité cognitive et verbale, permettent de prédire la valeur de son capital humain à l'âge adulte, comme son revenu et son emploi, de même que ses chances de participation à des activités criminelles ou dangereuses. Il n'y a rien de surprenant à ce que le développement de l'enfant soit intimement lié à ses antécédents

[...] si nous ne commençons pas dès maintenant à améliorer les principaux déterminants de la santé pour nos enfants et nos jeunes, notre inaction aura un impact considérable sur notre économie. En effet, les enfants ne finiront pas l'école ou n'iront pas à l'université, et ils ne pourront donc pas exercer les fonctions qu'exige le développement de notre économie.

*Marie Adèle Davis, directrice générale,
Société canadienne de pédiatrie,
28 mai 2008 (7:21).*

socioéconomiques. Bien des enfants issus de familles défavorisées prennent du retard très tôt dans la vie et il leur est difficile ensuite de se rattraper, d'où l'importance d'adopter à l'égard de la santé de la population une approche qui tient compte de toutes les étapes de la vie.

GRAPHIQUE 5
LE GRADIENT EN SANTÉ EST ÉVIDENT DANS LA PETITE ENFANCE



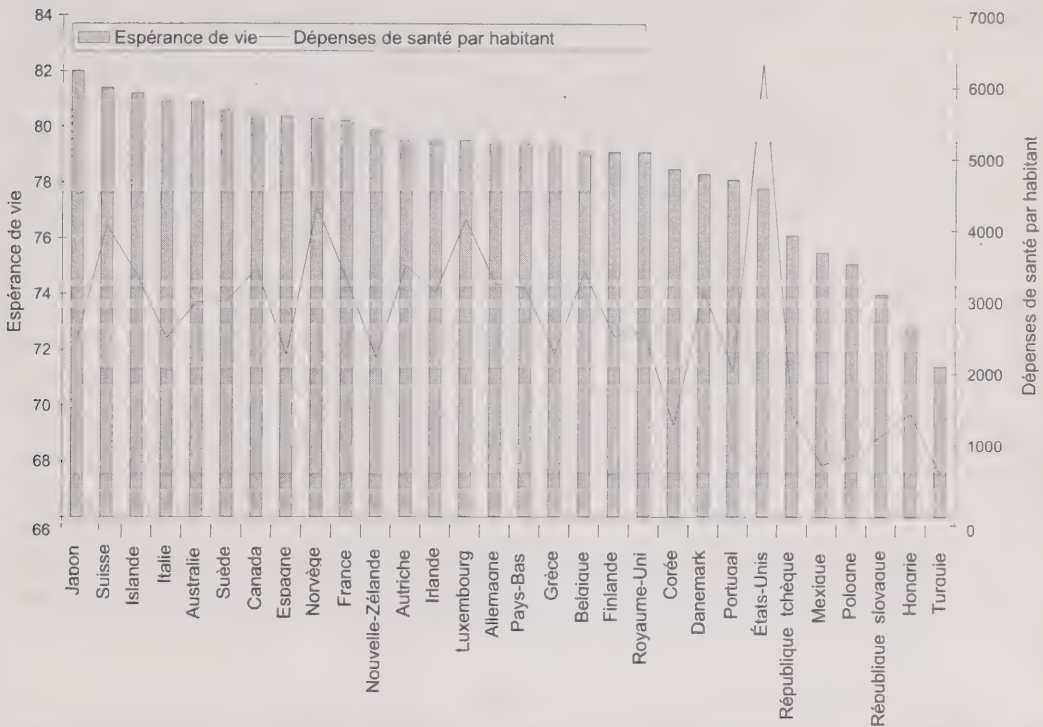
SFR : seuil de faible revenu

Source : Reproduit à partir d'Eleanor M. Thomas, La disposition à apprendre à l'école pour les jeunes de cinq ans au Canada, document de recherche, Statistique Canada, no 89-599-MIF au catalogue, 2006, p. 11, <http://www.statcan.gc.ca/pub/89-599-m/89-599-m2006004-fra.pdf>.

En résumé, les témoignages recueillis par le Sous-comité montrent que les Canadiens dont le niveau de scolarité et de revenu est supérieur sont en meilleure santé et perdent un moins grand nombre d'années de vie en raison de décès prématurés que ceux dont le niveau de scolarité et de revenu est inférieur. On a évalué que si tous les Canadiens avaient le même taux de décès prématurés que le un cinquième le plus fortuné de la population, il y aurait une diminution de 20 % du taux de décès prématurés de l'ensemble de la population. Cela équivaldrait à éliminer tous les décès prématurés attribuables à des blessures ou à des maladies cardiovasculaires⁶.

⁶ Rapport de l'administrateur en chef de la santé publique sur l'état de la santé publique au Canada, Agence de la santé du Canada, 2008, p. 71, <http://www.phac-aspc.gc.ca/publicat/2008/cpho-aspc/pdf/cpho-report-fra.pdf>.

GRAPHIQUE 6 : INVESTIR D'AVANTAGE DANS LES SOINS DE SANTÉ – AUCUNE GARANTIE D'AMÉLIORATION DE LA SANTÉ, OCDE 2005



Source : ECO-Santé OCDE 2008 et Service d'information et de recherche parlementaires, Bibliothèque du Parlement.

De plus, et nous l'avons entendu à maintes et maintes reprises tout au long de notre étude, la santé est largement tributaire de facteurs qui sont extérieurs au système de soins de santé. Plus important encore peut-être, le graphique 6 montre que l'augmentation des dépenses de santé ne garantit en rien l'amélioration de la santé. Par exemple, l'Indice euro-canadien des consommateurs de soins de santé place le Canada au 23^e rang sur 30 et au 30^e sur 30 au chapitre de l'optimisation des ressources. Autrement dit, cet indice montre que nous dépensons plus en soins de santé que les autres pays visés pour obtenir des résultats moindres⁷.

Il est clair que l'adoption d'une approche axée sur les déterminants de la santé s'impose, si le Canada veut se mettre au diapason de l'économie du XXI^e siècle. En fait, le Sous-comité croit fermement que nous ne pouvons nous y soustraire.

⁷ Health Consumer Powerhouse et Frontier Centre for Public Policy, *Euro-Canada Health Consumer Index 2008*, SC Policy Series N° 38, <http://www.fcpp.org/pdf/ECHCI2008finalJanuary202008.pdf>.

4. LA NÉCESSITÉ D'AGIR, LE COÛT DE L'INACTION

(...) toutes les entreprises du secteur privé ont de bonnes raisons d'agir sur les (...) déterminants de la santé, puisqu'elles ont tout intérêt à ce que leurs employés, leurs clients et les collectivités en général soient en santé. En fait, l'engagement des entreprises est essentiellement motivé par un souci de compétitivité, de productivité et de rentabilité. Les gouvernements et les collectivités désireuses de canaliser la capacité des grandes entreprises canadiennes d'agir pour améliorer la santé doivent être conscients de cette réalité et s'en servir pour coordonner leurs efforts en conséquence⁸.

En agissant sur les déterminants de la santé, il est possible d'améliorer la santé de la population, c'est-à-dire de s'attaquer aux causes des maladies et des blessures avant que celles-ci ne se déclarent ou ne se produisent. Il existe de solides arguments économiques et sociaux en faveur de l'amélioration de la santé physique et mentale de la population. Une politique sur la santé de la population ne fait pas qu'améliorer la santé et réduire les disparités en santé, elle stimule aussi la croissance économique, la productivité et la prospérité. Les enfants en santé réussissent mieux à l'école. Les travailleurs sont plus productifs s'ils sont en santé, et leur productivité accrue stimule, à son tour, la croissance économique. Les citoyens en santé sont plus actifs au sein de leur collectivité et contribuent ainsi à la cohésion sociale et au bien-être. Une population en bonne santé allège les dépenses gouvernementales au titre du soutien du revenu, des services sociaux, des soins de santé et de la sécurité. Autrement dit, la santé et la prospérité économiques du Canada sont tributaires de la santé de sa population.

Dans le contexte économique actuel, une politique sur la santé de la population – qui place la santé, la vie et le bien-être des gens au cœur des préoccupations – constitue une saine approche pour relancer l'économie. À cause de la récession, le chômage est en hausse et les conditions de vie des personnes et des familles sont gravement menacées ou déjà en péril. Le sentiment général, c'est que les disparités croissantes en santé, l'inégalité des revenus, la précarité sur le plan du logement et l'insécurité alimentaire pourraient avoir de graves et durables conséquences pour la santé et le bien-être. C'est pourquoi les investissements dans la santé de la population doivent faire partie intégrante des discussions sur le plan de relance économique.

La santé ne doit pas uniquement être perçue comme un actif clé du développement économique. Dans notre pays hautement civilisé, la santé pour tous doit à coup sûr être un objectif social prioritaire et une responsabilité de la société dans son ensemble. La santé est un besoin humain essentiel et, par conséquent, un droit humain fondamental. Elle est indispensable au bon fonctionnement des individus et des sociétés. Il convient donc de chercher à la préserver tout au long des différentes étapes de la vie, allant de la conception à l'enfance et de l'âge adulte à la vieillesse. Le Sous-comité estime en outre que les gouvernements ont l'obligation morale de faire en sorte que les conditions socioéconomiques, culturelles et environnementales permettent aux citoyens, aux collectivités et aux entreprises d'agir pour que tous les citoyens puissent vivre en bonne santé. Ce défi de taille ne peut être relevé que par l'adoption d'une approche pangouvernementale qui permettra de cibler la santé et les disparités en santé dans tous les

⁸ Conference Board of Canada's Roundtable of the Socio-Economic Determinants of Health, *Mémoire au Sous-comité*, 29 juin 2008, p. 3.

secteurs d'intervention (éducation, services sociaux et culturels, économie, environnement, alimentation, soutien du revenu, logement et infrastructure, fiscalité, etc.). Pour y arriver, il faudra, bien sûr, procéder à un profond remaniement structurel des politiques gouvernementales et de l'approche adoptée par les gouvernements à l'égard de leur élaboration et de leur mise en œuvre.

Certes, l'adoption et la mise en œuvre d'une politique sur la santé de la population ne sont pas une mince tâche, mais le refus d'agir à cet égard créera plus de problèmes et accroîtra même les disparités en santé au Canada. L'inaction sera très coûteuse en termes de dépenses directes en soins de santé, de coûts sociaux liés à l'aide sociale et à la criminalité, de perte de productivité et de qualité de vie réduite. Ces coûts sont énormes, se répercutent sur l'ensemble de l'économie et alourdissent le fardeau de tous les ordres de gouvernement et des ménages à titre individuel. Le présent rapport invite l'ensemble des ordres de gouvernement – de l'échelon fédéral à l'échelon local – de même que les entreprises, les organismes bénévoles, les collectivités et les citoyens à unir leurs efforts pour améliorer la santé de tous les Canadiens et réduire les disparités en santé d'un groupe à l'autre au sein de la population.

L'autre problème, c'est que nous savons combien il en coûtera si nous intervenons, mais que nous ne savons pas combien il en coûtera si nous ne faisons rien. Il faut préparer l'opinion publique en expliquant pourquoi, si nous n'intervenons pas, la situation va se détériorer, par exemple, dans les secteurs du logement social et de la sécurité du revenu. Les gens vont alors se demander s'il vaut mieux payer tout de suite plutôt que d'attendre, et ils vont comprendre que oui, il faut agir maintenant, car plus tard, ça coûtera plus cher.

Mel Cappe, président, Institut de recherche en politiques publiques, 26 février 2009 (1:22).

Le Sous-comité croit fermement que l'argent affecté à l'amélioration de la santé de la population est un investissement et non une dépense. C'est de plus un investissement avisé qui procure des avantages à court, moyen et long terme. Il va de soi que toute décision de dépenser comporte un coût de renonciation. Il faut maintenant prioriser les investissements pour venir à bout des disparités en santé. L'efficacité est alors de mise, c'est-à-dire qu'il faut optimiser l'utilisation des ressources.

PARTIE II : LA SANTÉ RAPPORTE – PASSONS À L'ACTION

1. UNE APPROCHE PANGOUVERNEMENTALE

[...] la santé des populations, dans toutes les dimensions de la question à l'étude par le comité, est maintenant un problème de grande importance pour le gouvernement et la population du Canada. Et l'idée du gouvernement d'adopter une « approche pangouvernementale » vis-à-vis de ce problème complexe a bien du sens, vu, surtout, le grand nombre d'acteurs institutionnels en cause⁹.

⁹ Jim Mitchell, partenaire fondateur, Le Cercle Sussex, le jeudi 26 février 2009 (1:14).

1.1 Une question de gouvernance

Dans une approche axée sur la santé de la population, il convient d'aborder de front tout l'éventail des déterminants de la santé. Chaque ordre de gouvernement doit adopter une approche pangouvernementale ou horizontale qui réunit les divers ministères et organismes (éducation, finances, emploi, santé, environnement, etc.). Il faut absolument agir de façon concertée afin de mener un travail de collaboration et de coordination pour la santé de la population – bien que nous sachions comme c'est difficile – puisque le Sous-comité estime qu'il est inacceptable pour un pays privilégié comme le Canada de continuer de tolérer des disparités en santé. Une intervention s'impose aussi en raison de l'actuelle récession économique qui risque d'accroître les disparités. Évidemment, il faudra opérer un profond changement de structure dans l'approche gouvernementale de l'élaboration et de la mise en œuvre des politiques d'intérêt public. Bien que l'approche que nous recommandons n'existe pas encore, bon nombre des composants essentiels sont déjà en place.

Tout au long de l'étude, nous avons demandé aux témoins comment il fallait structurer les rouages afin de permettre une approche pangouvernementale en santé de la population au sein du gouvernement fédéral. Il a souvent été question des moyens à prendre pour éliminer les vases clos et augmenter l'horizontalité. Nous avons entendu dire à maintes reprises qu'une direction provenant du plus haut niveau et de la part des organismes centraux est essentielle pour que l'approche pangouvernementale réussisse. Les témoins

ont souvent parlé de la politique pangouvernementale inédite adoptée en Angleterre afin de réduire les disparités en santé. La politique, dont la mise en œuvre était dirigée par le premier ministre, a mis à contribution 12 ministères et organismes centraux, ainsi que des autorités régionales et locales. Le ministère des Finances britannique a effectué un examen interministériel des dépenses afin de déterminer la meilleure utilisation des fonds pour réduire les disparités en santé. L'Australie constitue un autre exemple remarquable de coopération et de coordination interministérielles dans le cadre d'une initiative, dirigée par le premier ministre Kevin Rudd, visant à combler l'écart qui défavorise les autochtones (*Closing the Gap on Indigenous Disadvantage*). Un comité du Cabinet sur les affaires autochtones, présidé par le premier ministre, a été mis sur pied afin d'orienter l'initiative. Le Comité du Cabinet assure la cohérence de la direction entre les ministères et organismes gouvernementaux dans des domaines comme la sécurité communautaire, la petite enfance, le logement, l'éducation, la santé et la participation économique.

[...] la chose la plus importante, c'est que le premier ministre fasse de ce dossier une priorité du gouvernement et qu'il l'annonce à la population canadienne.

Jim Mitchell, partenaire fondateur, Le Cercle Sussex, 26 février 2009 (1:20).

Les témoins ont souvent demandé qui devrait présider un comité du Cabinet fédéral sur la santé de la population. L'honorable Monique Bégin, C.P., ancienne commissaire de la Commission des déterminants sociaux de la santé de l'OMS, a recommandé que le comité soit présidé par un ministre puissant, de préférence le premier ministre ou le vice-premier ministre, ou le ministre des Finances, mais pas le ministre de la Santé. D'autres témoins ont abondé dans le même sens. Le Sous-comité est aussi convaincu que la présidence du comité du Cabinet sur la santé de la population est une question cruciale puisqu'il faut une orientation claire de la part du premier ministre sur les mesures à prendre pour réduire les disparités en santé.

Les ministres de la Santé accaparent la plus grande part du budget de l'État. La crainte naturelle que les gens ont de l'impérialisme, qui n'est pas toujours qu'illusion, et le fait que le ministre de la Santé représente le lobby le plus puissant qui soit dans toute société, à mon humble avis et d'après mon expérience, soit la médecine organisée, sont des facteurs qui jouent contre ces ministres.

*Monique Bégin, 18 avril 2008
(4:105)*

Mais surtout, il est clair pour le Sous-comité que personne ne met en doute l'importance de la santé de la population et la nécessité de réduire les disparités en santé. Selon nous, la santé de la population n'est pas non plus une question partisane. Tous les partis politiques veulent réduire les disparités en santé au Canada, et cette question doit donc constituer une priorité absolue du programme du gouvernement. Par conséquent, le Sous-comité recommande :

Que le premier ministre du Canada prenne les devants pour annoncer, élaborer et mettre en œuvre, à l'échelon fédéral, une politique sur la santé de la population;

Qu'un comité du Cabinet sur la santé de la population soit créé et chargé de coordonner l'élaboration et la mise en œuvre de la politique fédérale sur la santé de la population;

Que le premier ministre du Canada préside le comité du Cabinet sur la santé de la population;

Que le comité du Cabinet sur la santé de la population soit composé des ministres compétents, notamment ceux qui dirigent les ministères et agences suivants : Ressources humaines et Développement des compétences, Affaires indiennes et du Nord canadien, Finances, Santé, Environnement, Justice, Agriculture et Agroalimentaire, Industrie, Agence de la santé publique et Condition féminine.

Dans une fédération où la politique sur la santé de la population relève du fédéral, des provinces et des territoires en plus des autorités régionales, il est absolument essentiel de se doter d'une structure de coordination pouvant appuyer et favoriser les consensus et la collaboration. Il est juste de dire que l'élaboration et la mise en œuvre de la politique sur la santé de la population au Canada se sont constamment déroulées sur un fond d'approches et de priorités diversifiées aux niveaux fédéral, provincial et territorial. Le Sous-comité estime que le premier ministre doit encore une fois prendre les devants et mettre à contribution et soutenir les autres ordres de

gouvernement en vue de la réalisation pancanadienne du programme de santé de la population. Nous pensons que l'approche que nous proposons devrait s'appliquer à tous les ordres de gouvernement. Par conséquent, le Sous-comité recommande :

Que le premier ministre du Canada convoque une réunion de tous les premiers ministres afin d'établir un mécanisme intergouvernemental de collaboration pour l'élaboration et la mise en œuvre d'une stratégie pancanadienne de santé de la population;

Que les premiers ministres des provinces annoncent, élaborent et mettent en œuvre dans leur compétence respective une politique sur la santé de la population inspirée de la politique fédérale;

Que, dans chaque province et territoire, les premiers ministres mettent sur pied et président un comité du Cabinet sur la santé de la population.

Outre le leadership et les structures de coordination nécessaires pour mettre en œuvre les stratégies et les politiques fédérales et provinciales sur la santé de la population, de nombreux modèles particuliers et nouveaux mécanismes seront requis afin de réaliser des initiatives horizontales (fédérales) et verticales (intergouvernementales). Les témoins entendus ont parlé de nombreux modèles fructueux dont on pourrait tirer des enseignements et qui pourraient, quand c'est possible, être élargis afin d'accroître la collaboration interministérielle et intergouvernementale. Parmi les exemples fédéraux, citons les Ententes sur le développement urbain, qui réunissent le gouvernement fédéral, les provinces et les municipalités dans le cadre d'approches complètes de revitalisation urbaine, le projet Quartiers en essor qui réunit des ministères fédéraux pour prendre des mesures concertées de revitalisation de quartiers, et le Partenariat rural canadien qui vise à promouvoir les intérêts ruraux auprès du gouvernement fédéral, en partenariat avec les collectivités. Parmi les projets provinciaux, citons Enfants en santé Manitoba et ActNow BC, qui ont tous les deux été présentés dans notre rapport intérimaire sur la perspective F-P-T.

Il convient de cerner plus systématiquement les enseignements que nous pouvons tirer de ces innovations si nous souhaitons vraiment accroître la capacité des gouvernements d'établir le degré de collaboration horizontale et verticale nécessaire en matière de santé de la population. Puisque le Secrétariat du Conseil du Trésor est l'organisme fédéral chargé d'établir les conditions des ententes de financement, le Sous-comité recommande :

Que le Secrétariat du Conseil du Trésor prenne les devants et élargisse la gamme des modèles et des ressources disponibles en vue de la gestion de collaborations horizontales et verticales.

Le Sous-comité reconnaît qu'un effort pancanadien de réduction des disparités en santé nécessite des connaissances spécialisées et une connectivité. Les connaissances spécialisées sont nécessaires afin d'appuyer le comité du Cabinet sur la santé de la population, et la connectivité sert à établir les liens voulus tant à l'horizontale qu'à la verticale. Nous croyons que c'est là un

mandat tout désigné pour l'Agence de la santé publique du Canada (ASPC), qui rend compte au Parlement par l'intermédiaire du ministre de la Santé.

Depuis de nombreuses années, l'Agence et Santé Canada, avant que l'Agence ne soit créée, sont à la fine pointe de la recherche et de la politique en santé de la population, à l'échelle tant nationale qu'internationale. La création de l'Agence a aussi donné lieu à l'établissement du Réseau pancanadien de santé publique qui comprend des représentants fédéraux, provinciaux et territoriaux. Forte de cet historique et de ces liens, l'Agence est bien placée pour agir comme source d'information pour le transfert de connaissances et la connectivité efficace qui seront nécessaires dans le cadre des nouvelles approches intersectorielles de collaboration en matière de santé de la population et de réduction des disparités en santé. Par conséquent, le Sous-comité recommande :

Que le gouvernement du Canada augmente le financement de l'Agence de la santé publique du Canada afin de créer un noyau de politiques et de connaissances qui servira de source d'information pour la mise en œuvre de politiques sur la santé de la population et la réduction des disparités en santé, tant à l'horizontale (à l'échelon fédéral) qu'à la verticale (collaboration intergouvernementale).

Étant donné que l'influence des déterminants de la santé se fait surtout sentir au niveau communautaire, il est clair que les administrations locales ou municipales ont un rôle à jouer. Le mieux serait que les dirigeants locaux et municipaux consacrent à la santé de la population autant d'attention et d'énergie que le gouvernement fédéral, les provinces et les territoires. Nous sommes toutefois conscients que les municipalités ne disposent pas de la même capacité d'intervention ni des mêmes ressources. Par conséquent, le Sous-comité recommande :

Que, dans la mesure du possible, les administrations locales ou municipales d'un bout à l'autre du pays adoptent et mettent en œuvre une vaste approche à l'égard de la santé de la population, au sein de leurs limites territoriales et en collaboration avec le gouvernement fédéral, les provinces et les territoires.

Jusqu'ici, le Sous-comité a abordé la coordination selon une orientation de haut en bas. Nous sommes toutefois convaincus que la coordination doit aussi être mise en œuvre de bas en haut. Un engagement descendant conjugué à un apport ascendant dans le réseau de services constituera une combinaison efficace. La coordination à l'échelon local ou communautaire est examinée à la partie 3 ci-après.

1.2 La nécessité d'une vision

[...] un ensemble d'objectifs nationaux, à la condition qu'ils soient concrets et non de simples généralités, joueraient un rôle très important et utile pour ce qui est d'orienter l'élaboration d'information sur la santé¹⁰.

En recommandant une approche pangouvernementale sur la santé des populations, le Sous-comité a pour objectif final d'améliorer les résultats en matière de santé et de réduire les disparités en santé. La vision primordiale qui préside à notre approche, comme nous l'avons déjà signalé, est de permettre à tous les Canadiens de s'épanouir, de vivre et de contribuer leur plein potentiel dans la société. Ceci aura ensuite pour effet d'améliorer la productivité et d'accroître la prospérité pour les générations à venir. Mais pour avoir une portée, la vision doit reposer sur des buts et des repères appropriés. Comme nous le verrons dans les paragraphes qui suivent, des progrès ont déjà été réalisés à cet égard.

Après avoir examiné les politiques sur la santé de la population au Canada et à l'étranger, le Sous-comité en est venu à la conclusion qu'il est essentiel qu'une approche pangouvernementale soit dotée de buts, d'objectifs et de cibles tangibles et mesurables. Ceux-ci permettront de cerner des domaines d'intérêt, de déterminer les données à recueillir et les indicateurs à suivre, d'établir des repères et de mesurer et de déclarer les progrès marqués. Dans les pays examinés, certains objectifs et cibles visaient des résultats précis en matière de santé (p. ex. la réduction de la mortalité et de la morbidité), tandis que d'autres insistaient sur l'adoption de modes de vie sains; quelques pays, comme l'Angleterre et la Suède, ont fixé des cibles pour la réduction des disparités en santé.

Au Canada, entre 1989 et 1998, chaque province a énoncé des buts en matière de santé qui, dès la fin des années 1990, ont été abandonnés¹¹. En 2004, une importante percée a été réalisée dans le programme de la santé de la population lorsque les premiers ministres du Canada se sont engagés à élaborer « des objectifs et des cibles pour améliorer l'état de santé de la population canadienne en s'alliant à des experts »¹². Les ministres de la Santé fédéral, provinciaux et territoriaux se sont entendus en 2005 sur un ensemble d'objectifs en matière de santé divisés en quatre catégories : besoins fondamentaux dans les milieux social et physique; l'appartenance et l'engagement; les modes de vie sains; un système de santé (voir le tableau ci-après).

¹⁰ Michael Wolfson, statisticien en chef adjoint, Analyse et développement, Statistique Canada, 30 avril 2008 (5:9).

¹¹ Deanna L. Williamson et autres, « Implementation of Provincial/Territorial Health Goals in Canada », *Health Policy*, vol. 64, 2003, p. 173-191.

¹² Réunion des premiers ministres, *Un plan décennal pour consolider les soins*, 14 septembre 2004, p. 7, http://www.scics.gc.ca/cinfo04/800042005_f.pdf.

OBJECTIFS DE SANTÉ POUR LE CANADA	
<i>Besoins fondamentaux (milieux social et physique)</i>	<ul style="list-style-type: none"> Nos enfants atteignent leur plein potentiel et grandissent heureux, confiants, en santé et en sécurité. L'air que nous respirons, l'eau que nous buvons, la nourriture que nous mangeons et les milieux dans lesquels nous vivons, travaillons et nous divertissons sont sécuritaires et sains, aujourd'hui et pour des générations à venir.
<i>Appartenance et engagement</i>	<ul style="list-style-type: none"> Chaque personne vit dans la dignité, a un sens d'appartenance et contribue à des familles, des groupes d'amis et des collectivités diverses qui favorisent l'entraide. Nous apprenons tout au long de la vie par le biais de l'enseignement formel et informel et de relations avec autrui et avec la terre. Nous contribuons aux décisions qui touchent notre santé et notre bien-être personnels et collectifs, et nous influons sur ces décisions. Par le biais du leadership, de la collaboration et des connaissances, nous travaillons à faire du monde un endroit sain pour tous.
<i>Modes de vie sains</i>	<ul style="list-style-type: none"> Chaque personne reçoit le soutien et l'information dont elle a besoin pour faire des choix sains.
<i>Un système de santé</i>	<ul style="list-style-type: none"> Nous travaillons sur la prévention des menaces pour notre santé et notre sécurité par le biais d'efforts coordonnés à l'échelle nationale et internationale, et nous sommes prêts à réagir à de telles éventualités. Un solide réseau de santé et de bien-être social qui réduit les écarts dans les états de santé et qui offre des soins appropriés, au moment opportun.

Source : *Objectifs de santé pour le Canada – Engagement fédéral-provincial-territorial envers tous les Canadiens*, octobre 2005, <http://www.phac-aspc.gc.ca/hgc-osc/home-f.html>.

Sous la direction de l'Agence de santé publique du Canada, les Objectifs de santé pour le Canada ont été établis dans le cadre d'un vaste processus de consultation et de validation où les provinces, les territoires, des experts en santé publique, des intervenants et des citoyens ont mis en commun leurs connaissances et leur vision d'un Canada en santé. Plus de 300 intervenants et spécialistes ont participé à 12 tables rondes tenues dans les provinces et les territoires, à

cinq activités thématiques, à cinq dialogues à caractère délibératif ainsi qu'à des consultations avec des parlementaires. En outre, près de 400 personnes, groupes et organisations ont fait part de leurs commentaires et suggestions par l'intermédiaire d'une enquête en ligne ou dans le cadre de leur propre consultation. Le processus de consultation a débouché sur la rédaction des énoncés des objectifs, qui ont été validés par des partenaires gouvernementaux et non gouvernementaux, des spécialistes de la santé publique et des intervenants. Quoiqu'impressionnant, ce processus de consultation exhaustif n'a pas donné lieu à une stratégie pancanadienne ni à des interventions mesurables.

À la lumière des renseignements sur la mise en œuvre d'objectifs en matière de santé à l'échelle internationale, et malgré l'absence de progrès dans ce domaine sur la scène canadienne, le Sous-comité a conclu dans son rapport sur les *Enjeux et options* « que l'établissement de buts peut aider à mobiliser les ressources afin d'appuyer les initiatives en santé de la population, à suivre les progrès accomplis et à en faire rapport, ainsi qu'à accélérer l'élaboration d'indicateurs de la santé et de systèmes d'information sur la santé »¹³. Nous sommes convaincus que le cadre des Objectifs de santé pour le Canada, s'il est repris et repose sur de solides repères et indicateurs, pourrait servir de mécanisme pour orienter les investissements fédéraux, provinciaux, territoriaux et locaux pour améliorer la santé. Par conséquent, le Sous-comité recommande :

Je dois préciser que je ne crois pas que le Canada doive tenter d'établir de nouveaux objectifs. Nous en avons déjà. Nous avons besoin d'indicateurs, de cibles et de stratégies qui nous permettent de savoir ce que nous visons, comment nous voulons nous y prendre et quand nous voulons y arriver [...] Alors, l'objectif global en tant que nation consiste à bâtir un pays dont la population est aussi en santé qu'elle le peut physiquement, mentalement, émotionnellement et spirituellement, ce qui est primordial pour faire tourner la roue médicale.

L'honorable Carolyn Bennett, députée, 11 juin 2008 (7:80).

Que les Objectifs de santé pour le Canada adoptés en 2005 soient rétablis et orientent l'élaboration, la mise en œuvre et le suivi de la politique pancanadienne sur la santé de la population.

Les Objectifs de santé pour le Canada doivent être assortis d'indicateurs ou de cibles appropriés concernant les disparités en santé. Il n'existe pas à l'heure actuelle d'ensemble national d'indicateurs sur les disparités en santé, mais le Groupe d'experts sur la promotion de la santé de la population a amorcé l'élaboration d'un tel ensemble. Le Sous-comité se réjouit que ce groupe fédéral-provincial-territorial ait été chargé d'élaborer des indicateurs pancanadiens cohérents et exhaustifs concernant les disparités en santé. Par conséquent, le Sous-comité recommande :

Que le Groupe d'experts sur la promotion de la santé de la population accélère ses travaux afin de terminer d'ici douze mois l'élaboration d'un ensemble national d'indicateurs des disparités en santé;

¹³ Sous-comité sur la santé des populations, *op. cit.*, p. 17.

Que ces indicateurs des disparités en santé soient mis en rapport avec les Objectifs de santé pour le Canada.

1.3 L'examen interministériel des dépenses

En Angleterre, la nouvelle politique pangouvernementale sur la santé de la population a été mise en place après un examen interministériel des dépenses réalisé en 2002 sous la direction du ministère des Finances, et qui a permis de passer en revue l'ensemble des programmes gouvernementaux afin de déterminer les façons d'utiliser les dépenses publiques le plus efficacement possible pour réduire les disparités en santé. Les résultats de l'examen des dépenses ont orienté les plans de dépenses ministériels des exercices 2003-2004 à 2005-2006. En outre, ils ont abouti à des engagements obligatoires d'agir pour réduire les disparités en santé.

À l'échelon fédéral au Canada, plusieurs initiatives pangouvernementales d'examen et de réaffectation des dépenses ont été réalisées depuis 2003. Le gouvernement a expliqué qu'étant donné l'évolution constante des demandes de ressources, les programmes doivent être examinés à intervalles réguliers. Puisqu'un processus d'examen existe déjà, le Sous-comité estime qu'il faudrait entreprendre un examen interministériel des dépenses semblable à celui lancé par le ministère des Finances britannique en 2002, afin de cerner les programmes qui ont une incidence sur la santé et de réaffecter les fonds aux programmes visant les disparités en santé. Par conséquent, le Sous-comité recommande :

Que le ministère des Finances, en collaboration avec le Bureau du Conseil privé et le Secrétariat du Conseil du Trésor, effectue un examen interministériel des dépenses en vue d'affecter les ressources aux programmes qui contribuent à réduire les disparités en santé.

1.4 Une optique santé dans toutes les politiques

Comme nous l'avons déjà souligné, les déterminants de la santé les plus puissants ne relèvent pas vraiment du domaine de la santé. En fait, ce sont les politiques dans les secteurs autres que celui de la santé qui présentent le plus grand potentiel d'améliorer (ou d'empirer) la santé et le bien-être de la population et de réduire les disparités en santé. En conséquence, de nombreux témoins ont souligné qu'il faudrait évaluer l'incidence possible de ces politiques sur la santé avant de les mettre en œuvre. L'étude d'impact sur la santé (EIS), aussi appelée évaluation des incidences sur la santé, est la méthode officielle utilisée pour prédire les effets possibles d'une politique, et elle permet d'accorder une attention particulière à l'incidence sur les disparités en santé. L'EIS est donc utile pour prendre en compte les enjeux liés à la santé lors de l'établissement de politiques à l'échelle du gouvernement.

En 1997, le mémoire sur la santé de la population recommandait notamment au Cabinet fédéral d'appliquer l'étude d'impact sur la santé à toutes les politiques et les programmes fédéraux. Bien que la recommandation ait été adoptée, les compressions de dépenses exercées par la suite ont nui à sa mise en œuvre, et seul Santé Canada a agi pour examiner ses programmes et ses initiatives dans une optique de santé de la population. Depuis, Santé Canada a publié, en collaboration avec le Comité fédéral-provincial-territorial de l'hygiène du milieu et du

travail, le *Guide canadien d'évaluation des incidences sur la santé*¹⁴. Parallèlement, plusieurs provinces ont prôné le recours à l'étude d'impact sur la santé, et plusieurs rapports provinciaux ont recommandé que de telles études figurent dans tous les mémoires au Cabinet. En 1993, la Colombie-Britannique a intégré une étude d'impact sur la santé obligatoire dans le processus officiel d'analyse des politiques au Cabinet, mais l'étude est devenue facultative en 1999, après un changement de gouvernement.

Certains pays, comme la Suède et la Nouvelle-Zélande, ainsi que la province de Québec, ont légiféré en santé publique afin que l'étude d'impact sur la santé fasse partie intégrante de l'élaboration des politiques gouvernementales. La loi québécoise confère au ministre de la Santé un pouvoir d'initiative qu'il peut mettre à profit en donnant des avis à ses collègues des autres ministères afin de promouvoir la santé et de soutenir l'adoption de politiques publiques favorables à la santé de la population. Afin d'orienter les autres ministères quant à l'utilisation des études d'impact sur la santé, le ministère de la Santé et des Services sociaux du Québec a produit son propre guide sur l'évaluation d'impact sur la santé fondé sur les modèles élaborés en Europe et l'a adapté aux besoins interministériels¹⁵. Jusqu'à maintenant, l'évaluation d'impact sur la santé a servi, par exemple, à interdire l'utilisation des téléphones cellulaires dans les voitures et à réglementer l'exploitation minière de l'amiante.

Au cours des audiences du Sous-comité, certains témoins ont brandi l'exemple de l'actuel processus fédéral d'évaluation d'impact sur l'environnement (EIE) comme outil d'évaluation utile. Une directive du Cabinet exige que tout projet de politiques, de plans ou de programmes soumis à l'approbation d'un ministre ou du Cabinet et qui risque d'entraîner des effets environnementaux importants, tant positifs que négatifs, fasse l'objet d'une évaluation environnementale stratégique. La directive énonce également des critères pour aider les ministères et organismes fédéraux à déterminer s'il convient de mener une telle évaluation et offre des conseils sur la manière de la préparer¹⁶. L'Agence canadienne d'évaluation environnementale aide les ministères à améliorer leur capacité de mener des EIE. Le ministre de l'Environnement doit informer les autres ministres des effets environnementaux potentiels des projets avant la prise de décision du Cabinet et les aviser sur les mesures appropriées à prendre en matière d'environnement. Il ne s'agit pas d'un droit de veto ni d'un rôle d'approbation. Dans le cadre de leurs fonctions, les ministres doivent respecter les objectifs environnementaux fondamentaux du gouvernement et les objectifs de développement durable. En vertu de la *Loi sur le vérificateur général*, le commissaire à l'environnement et au développement durable doit superviser les efforts du gouvernement visant à protéger l'environnement et à favoriser le développement durable. Le Bureau du Conseil privé joue également un rôle puisqu'il doit s'assurer que les ministères et organismes se conforment à la directive lorsqu'ils examinent des projets destinés au Cabinet. De plus, Environnement Canada fournit des conseils spécialisés.

¹⁴ Santé Canada, *Guide canadien d'évaluation des incidences sur la santé*, 2004, http://www.hc-sc.gc.ca/ewh-semt/pubs/eval/handbook-guide/vol_1/index-fra.php.

¹⁵ Ministère de la Santé et des Services sociaux (Québec), *Guide pratique : Évaluation d'impact sur la santé lors de l'élaboration de projet de loi et de règlement au Québec*, 2006, <http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2006/06-245-01.pdf>.

¹⁶ Bureau du Conseil privé, *Évaluation environnementale stratégique – La directive du Cabinet sur l'évaluation environnementale des projets de politiques, de plans et de programmes*, 2004, http://www.ceaa-acee.gc.ca/016/CEAA-StrategicFinal_f.pdf.

Dans son rapport sur les *Enjeux et options*, le Sous-comité a affirmé que : « [l]'étude d'impact sur la santé pourrait être considérée comme un premier pas vers l'élaboration d'une politique sur la santé de la population, puisqu'elle permettrait de mieux comprendre comment la plupart des politiques publiques influent d'une manière ou d'une autre sur la santé de la population. À notre avis, l'étude d'impact sur la santé est un moyen pratique d'évaluer les effets possibles sur la santé d'une politique, d'un programme ou d'un projet donné, en particulier les effets sur les groupes vulnérables ou défavorisés; elle pourrait maximiser les effets positifs et réduire au minimum les effets négatifs sur la santé des propositions provenant de tous les secteurs du gouvernement¹⁷. »

Fait à souligner, d'après les témoignages recueillis, nous estimons que le Canada dispose déjà des atouts nécessaires afin d'appliquer l'étude d'impact sur la santé comme stratégie pour élaborer et mettre en œuvre une politique sur la santé de la population. À notre avis, légiférer ne constitue peut-être pas le meilleur moyen d'institutionnaliser ces études, et le processus risque d'être long. Cependant, une directive du Cabinet, comme celle applicable à l'évaluation d'impact environnemental, sera nécessaire afin d'imposer la mise en œuvre de l'étude d'impact sur la santé. Par conséquent, le Sous-comité recommande :

Que le gouvernement du Canada exige la tenue d'une étude d'impact sur la santé pour tout projet de politiques, de plans ou de programmes soumis au Cabinet et susceptible d'avoir d'importantes répercussions sur la santé;

Que le Conseil privé, en collaboration avec Santé Canada, élabore des lignes directrices pour la mise en œuvre de la directive du Cabinet sur l'étude d'impact sur la santé;

Que les lignes directrices sur l'étude d'impact sur la santé soient élaborées au moyen des documents existants;

Que le gouvernement du Canada favorise le recours à l'étude d'impact sur la santé dans toutes les provinces et les territoires.

¹⁷ Sous-comité sur la santé des populations, *op. cit.*, p. 19.

2. INFRASTRUCTURE DE BASE DE DONNÉES

L'approche pangouvernementale en matière de santé de la population doit s'appuyer sur le développement d'une solide infrastructure de base de données qui permettra de recueillir, de suivre, d'analyser et de partager des données sur les indicateurs de santé et les indices de disparités en santé, et sur un ambitieux programme de recherche interventionnelle. Tous les pays dont le Sous-comité a établi le profil – Australie, Angleterre, Finlande, Nouvelle-Zélande, Norvège et Suède – se sont dotés de solides bases de données sur les indicateurs de santé. En Norvège, en Suède et en Finlande, des instituts nationaux de santé publique suivent de près l'état de santé de la population et font le point régulièrement. L'étendue des disparités en matière de santé est particulièrement bien documentée en Angleterre et en Nouvelle-Zélande.

Comment le Canada se compare-t-il à ces pays pour ce qui est de recueillir des données sur la santé et les disparités, d'en faire le suivi et de faire le point sur la situation? Selon les témoignages recueillis par le Sous-comité, le Canada possède de solides données sur l'état de santé de la population selon chaque déterminant de même que sur les disparités en santé. Au niveau national, Statistique Canada, l'Initiative sur la santé de la population canadienne, l'Agence de la santé publique du Canada et Ressources humaines et Développement des compétences Canada sont des sources d'information fiables. Au niveau provincial, il existe aussi plusieurs sources utiles d'information sur les indicateurs de santé et les disparités en santé, notamment le Manitoba Population Health Data Repository (dépôt de données sur la santé de la population du Manitoba), les Community Accounts (comptes communautaires) à Terre-Neuve-et-Labrador et le British Columbia Health and Wellness Survey (sondage sur la santé et le bien-être en Colombie-Britannique). Au niveau local, divers organismes gouvernementaux et non gouvernementaux fournissent de l'information utile sur les indicateurs de santé et le bien-être, comme le Secrétariat rural (base de données sur les collectivités), la Fédération canadienne des municipalités, l'Atkinson Charitable Foundation et le Conseil canadien de développement social. Ensemble, ces sources d'information facilitent le développement des connaissances ciblées et des données scientifiques nécessaires à l'avancement du dossier de la santé de la population.

2.1 Un système pancanadien de comptes communautaires

Les comptes communautaires sont [...] une ressource fantastique. Je n'arrive pas à imaginer comment je pourrais faire mon travail sans ceux-ci, pas plus que je n'arrive à imaginer comment les autres provinces font pour s'en passer. Les comptes communautaires offrent de l'information extraordinaire dans un contexte très convivial, et les données peuvent facilement être transformées en connaissances qui nous permettent de mieux comprendre l'état de santé de nos collectivités¹⁸.

Le Sous-comité s'est fait dire à maintes reprises que même si le Canada dispose d'excellentes sources provinciales et nationales d'information sur la santé de la population, il manque de données fiables au niveau local. Comme l'interaction des politiques touchant la santé de la population se fait surtout sentir au niveau local, il convient de recueillir davantage d'information à ce niveau. De nombreux témoins sont d'avis que nous pourrions nous inspirer

¹⁸ Lisa Brown, spécialiste de la planification, Eastern Health, Terre-Neuve-et-Labrador, 21 mai 2008 (6:121).

des Community Accounts (CA) de Terre-Neuve-et-Labrador pour mettre en place l'infrastructure de base de données nationale nécessaire à la mise en œuvre d'une vaste politique sur la santé de la population. La Nouvelle-Écosse s'est dotée d'une variante des CA, et l'Île-du-Prince-Édouard a récemment lancé des projets pilotes de CA (dans le cadre de la Quality of Island Life Cooperative). Les CA pourraient aussi être utiles aux collectivités autochtones et, de fait, l'Institut de statistiques des Premières nations songe à s'en servir comme modèle de base de données.

Les CA sont un système d'échange et de consultation de données en ligne, d'accès illimité et gratuit, qui permet la consultation et l'analyse de données sociales, économiques et environnementales (santé, revenu, éducation, emploi, production, ressources, criminalité, etc.) provenant de diverses sources (Statistique Canada, ministères, hôpitaux, etc.), tant locales que régionales et provinciales. La composante de base utilisée sur le plan géographique est le code postal. Les CA sont administrés par l'agence de la statistique de Terre-Neuve-et-Labrador, qui relève du ministère des Finances de la province. Ils ont plusieurs utilisateurs, notamment les ministères, les régies régionales, les collectivités, les universitaires et les chercheurs, les ONG et les particuliers. Le programme des CA est l'une des principales sources d'information consultée lorsque vient le temps de faire le point sur les progrès accomplis grâce aux différentes initiatives provinciales mises en œuvre pour réduire les disparités en santé, par exemple, le plan d'action pour réduire la pauvreté, le plan provincial pour le mieux-être et le Secrétariat rural.

Le Sous-comité est d'avis que les CA ont été très utiles au couplage de données sur la santé de la population, le bien-être des collectivités et le développement économique. Nous sommes particulièrement impressionnés par les progrès accomplis par Terre-Neuve-et-Labrador en ce qui concerne la mise en œuvre d'une solide infrastructure de base de données sur la santé de la population et nous nous réjouissons de voir que la Nouvelle-Écosse et l'Île-du-Prince-Édouard ont adopté un modèle semblable. Nous croyons qu'une telle base de données est un élément clé de l'élaboration et de la mise en œuvre d'une politique pancanadienne sur la santé de la population. Par conséquent, le Sous-comité recommande :

Que le gouvernement du Canada appuie l'élaboration et la mise en œuvre d'un programme de comptes communautaires, inspiré de celui de Terre-Neuve-et-Labrador, dans l'ensemble des provinces et territoires.

L'autre système d'infrastructure qui pourrait être exploité très avantageusement aux fins de la santé de la population au Canada est celui utilisé pour gérer les dossiers de santé électroniques (DSE), qu'Inforoute Santé du Canada Inc. s'affaire actuellement à mettre en œuvre en collaboration avec les gouvernements provinciaux et territoriaux. Les DSE renferment des renseignements médicaux concernant les patients et donnent aussi accès aux données conservées par les différents fournisseurs de soins d'une province ou d'un territoire à l'autre. Les renseignements médicaux accessibles sont vastes : rapports cliniques, données sur l'immunisation, médicaments délivrés sur ordonnance, résultats

[...] [J]e parlerai de ce que les dossiers de santé électroniques peuvent apporter aux données et renseignements qui pourraient servir à la création d'un système d'information sur la santé de la population.

*Mike Sheridan, chef de l'exploitation,
Inforoute santé du Canada Inc.,
27 mars 2009 (3:44).*

de tests en laboratoire, imagerie diagnostique et renseignements sur l'état de santé actuel et passé. Pour cette raison, les DSE peuvent fournir de l'information longitudinale ou des données sur les différentes étapes de la vie – allant de la grossesse à la vieillesse, en passant par le développement de la petite enfance, les années d'études et l'adolescence, le monde du travail puis la retraite – qui sont utiles aux fins de la politique sur la santé de la population. De plus, comme les comptes communautaires, les DSE peuvent être regroupés et analysés par code postal. En conséquence, de nombreux témoins ont affirmé au Sous-comité que les possibilités de couplage de données sur une même personne offertes par les futurs DSE sont énormes, si nous nous dotons en plus d'une vaste infrastructure de bases de données de comptes communautaires.

Parce qu'il existe actuellement plusieurs sources nationales, provinciales et locales d'information sur les disparités en santé, le Sous-comité a souvent interrogé les témoins pour savoir à qui devraient être confiés l'établissement, la gestion et l'entretien d'un tel système national de base de données. De nombreux témoins ont insisté pour dire qu'il ne fallait surtout pas créer de nouvelles entités, mais chercher plutôt à établir un partenariat entre les principaux organismes compétents en la matière. Il est largement reconnu que l'ICIS – l'Institut canadien d'information sur la santé – a été un fructueux modèle de partenariat au Canada. Malgré sa taille modeste, l'ICIS a contribué à jeter des ponts entre les nombreux autres groupes œuvrant à l'échelle nationale, ainsi qu'entre les provinces et territoires. Le Sous-comité souscrit à l'avis des témoins qui estiment que l'ICIS a accompli un très bon travail, au cours des 15 dernières années, comme dépositaire de l'information sur la santé, en collaboration avec l'ensemble des provinces et territoires. Sa compétence est reconnue depuis longtemps et sa réputation n'est plus à faire. La prochaine étape, à notre avis, consiste pour l'ICIS à étendre ses partenariats à d'autres intervenants clés dans le domaine de la santé de la population en général. Par conséquent, le Sous-comité recommande :

Que le développement, la gestion et le maintien de l'infrastructure de base de données pancanadienne sur la santé de la population soient confiés à l'Institut canadien d'information sur la santé;

Que l'ICIS entreprenne sans délai le travail d'intégration verticale des données nécessaire à cette fin, avec la collaboration des principaux partenaires.

Des témoins ont pris soin de souligner que le couplage des données des DSE et de la base données des CA s'avère toutefois extrêmement délicat du point de vue de la protection des renseignements personnels. Le Sous-comité est conscient que le droit à la protection de la vie privée et à la confidentialité des dossiers médicaux personnels est une valeur très importante aux yeux des Canadiens. Maintenant plus que jamais, les Canadiens veulent obtenir l'assurance que leur vie privée et la confidentialité des renseignements les concernant seront respectées en cette ère d'évolution technologique rapide. Il faut toutefois parvenir à un juste équilibre entre la protection des renseignements personnels et l'utilisation de l'information recueillie sur un groupement de population pour prendre des décisions éclairées concernant les politiques et les stratégies gouvernementales. Le Sous-comité est conscient que Statistique Canada a le mandat législatif et constitutionnel le plus solide en matière de couplage de données, qu'il affiche un bilan irréprochable au chapitre de la confidentialité et de la protection de la vie privée et qu'il possède une expertise technique et un leadership dans ce domaine depuis les années 1960. Par conséquent, le Sous-comité recommande :

Nous devons reconnaître que l'information sur la santé – et je dis « information » parce qu'il s'agit non seulement de la santé mais aussi des services sociaux et du chômage – est un bien collectif. [...] Nous devons utiliser tous les renseignements que nous recueillons à propos des citoyens pour en apprendre davantage sur la société : où nous en sommes, quelle direction nous prenons, comment nous nous tirons d'affaire, où nous nous situons par rapport au reste du pays et par rapport aux autres pays. Cet exercice est essentiel pour faciliter la collecte de cette information.

*Jean-Marie Berthelot, vice-président,
Programmes, Institut canadien d'information
sur la santé, 27 mars 2009 (3:56).*

Que Statistique Canada, en collaboration avec Inforoute Santé du Canada Inc., l'Institut canadien d'information sur la santé et d'autres intervenants clés, élabore des normes pour faciliter le couplage de données entre les comptes communautaires et les Dossiers de santé électroniques sans pour autant compromettre la protection, la confidentialité et la sécurité des renseignements personnels;

Que l'élaboration des normes nécessaires à la protection, à la confidentialité et à la sécurité des renseignements personnels soit terminée d'ici les douze prochains mois.

2.2 Recherche interventionnelle en santé des populations

Le Sous-comité s'est fait dire à maintes reprises que toute bonne politique gouvernementale doit faire la démonstration constante de son efficacité, autant à l'étape de sa conception qu'après sa mise en œuvre. Cette démonstration exige une analyse intelligente et rigoureuse, qui doit elle-même reposer sur des données et de l'information pertinentes. Comme les connaissances sur la santé de la population sont incomplètes et qu'elles le resteront probablement dans un avenir prévisible, l'élaboration et la mise en œuvre d'une politique se feront inévitablement sans qu'on sache exactement ce qui fonctionne ou non. Voilà pourquoi il est essentiel de constamment contrôler et évaluer les stratégies et programmes, et d'en revoir régulièrement la conception, suivant les résultats obtenus. Au fil du temps, ce type de recherche, souvent appelé « recherche interventionnelle », nous aidera à mieux comprendre quels sont les programmes et les stratégies efficaces pour améliorer la santé de la population et réduire les disparités en santé.

J'aimerais maintenant poursuivre avec l'examen du deuxième enjeu : investir davantage dans la recherche sur la santé de la population et améliorer l'application des connaissances. Je tiens à mettre en évidence les deux options possibles et à indiquer laquelle constituerait une erreur, selon moi. En effet, il serait insensé d'investir principalement dans la connaissance des déterminants généraux des résultats en matière de recherche. Il s'agit là de l'option la plus facile, et beaucoup de ces déterminants sont déjà connus. Il faut plutôt combler l'énorme écart des savoirs sur les interventions efficaces de la politique publique. Cela peut commencer à ressembler à une évaluation de programme, et c'est effectivement le cas en grande partie. Toutefois, il s'agit d'une évaluation de programme impartiale qui respecte des normes rigoureuses de qualité. Elles se plient également à des normes méthodologiques cohérentes ce qui permet de faire confiance dans une certaine mesure aux coefficients coûts-avantages relatifs de différentes interventions. Le Canada n'a pas investi suffisamment dans une telle évaluation efficace et impartiale, soumise à des normes de qualité et revue par des pairs, surtout dans le domaine de la santé de la population.

*Cliff Halliwell, directeur général, Direction générale de la recherche en politiques stratégiques, Ressources humaines et Développement social Canada,
30 avril 2008 (5:12-13).*

Comme le Sous-comité l'a indiqué dans son rapport *Enjeux et options*, il est difficile de savoir quelles sont au juste les dépenses du Canada au titre de la recherche sur la santé de la population¹⁹. À l'heure actuelle, un certain nombre d'organismes et de ministères fédéraux jouent un rôle dans l'orientation, le financement et la conception de la recherche sur la santé de la population, notamment les Instituts de recherche en santé du Canada, Statistique Canada, l'Institut canadien d'information sur la santé, Santé Canada, l'Agence de la santé publique du Canada (et ses six centres nationaux de collaboration), d'autres ministères fédéraux (comme Affaires indiennes et du Nord Canada, Ressources humaines et Développement des compétences Canada, Environnement Canada, etc.) et d'autres organismes subventionnaires comme le Conseil de recherches en sciences naturelles et en génie (CRSNG) ou le Conseil de recherches en sciences humaines (CRSH). En outre, de multiples ministères, organismes et instituts provinciaux participent à la recherche interventionnelle. Des témoins ont toutefois insisté sur le fait que le financement actuel n'est pas à la mesure du fardeau que représentent les disparités

¹⁹ Sous-comité sur la santé des populations, *Politiques sur la santé de la population : enjeux et options*, avril 2008, p. 14.

actuelles en matière de santé et qu'il faudrait disposer de plus de renseignements factuels et scientifiques sur ce qui fonctionne et ce qui ne fonctionne pas pour améliorer la santé de la population. Le Sous-comité croit que la recherche interventionnelle est un élément essentiel de toute approche pangouvernementale à l'égard de la santé de la population. Par conséquent, nous recommandons :

Que les Instituts de recherche en santé du Canada (IRSC) travaillent en collaboration avec les ministères et organismes fédéraux compétents afin d'évaluer les investissements actuels dans la recherche interventionnelle en santé des populations et d'en arriver à un consensus sur ce que devrait être le niveau de financement dans ce domaine;

Que le gouvernement du Canada investisse davantage dans la recherche interventionnelle en santé des populations pour que le niveau de financement corresponde à celui convenu par les IRSC et les autres ministères et organismes compétents;

Qu'à l'avenir, la recherche interventionnelle en santé des populations financée par le gouvernement du Canada mise sur les capacités et les atouts des réseaux et des centres de recherche existants et encourage l'établissement de partenariats fondés sur la coopération entre les organismes de recherche municipaux, provinciaux et fédéraux ainsi qu'avec les milieux universitaires, en vue de la réalisation d'un programme de recherche ciblé;

Que le gouvernement du Canada mette au point des mécanismes de financement concurrentiels afin de mieux soutenir l'innovation et la recherche interventionnelle de pointe en santé des populations;

Que le gouvernement du Canada envisage l'adoption de mécanismes de financement conjoints pour soutenir les activités interprovinciales et internationales de recherche interventionnelle comparative en santé des populations;

Que le gouvernement du Canada examine les critères d'admissibilité au fonds pour l'infrastructure de recherche en santé humaine au Canada et essaie de voir comment ceux-ci pourraient mieux cadrer avec la recherche interventionnelle en santé des populations assortie de mécanismes de mise en œuvre dans le domaine de la santé et dans d'autres secteurs;

Que la recherche interventionnelle en santé des populations portant sur le logement, le développement de la petite enfance et l'atténuation des effets de la pauvreté sur les Autochtones et les autres populations vulnérables soit considérée comme prioritaire.

3. METTRE LES COLLECTIVITÉS À CONTRIBUTION

L'étonnante constance avec laquelle les déterminants de la santé sont revenus au cours des consultations des organismes communautaires d'un bout à l'autre du Canada laisse supposer qu'un consensus implicite existe déjà à ce sujet. On peut conclure sans trop craindre de se tromper que les organismes communautaires représentent une riche ressource qui attend seulement d'être exploitée. Le gouvernement fédéral peut mobiliser cette ressource en appuyant la participation des collectivités à l'action intersectorielle (...)²⁰.

Au cours de son étude, le Sous-comité a entendu divers témoins et reçu de nombreux mémoires proposant une multitude d'approches destinées à améliorer la santé de la population et à réduire les disparités en santé. Tous s'entendent sur un point essentiel : les gouvernements ne peuvent agir seuls. Les actions pouvant le plus efficacement améliorer la santé et le bien-être, accroître la productivité, favoriser la cohésion sociale et réduire la criminalité doivent être entreprises à l'échelon communautaire et dirigées par les collectivités elles-mêmes.

Nous sommes d'accord avec l'administrateur en chef de la santé publique du Canada qui, dans son premier rapport (2008), a réclamé explicitement le renforcement des collectivités canadiennes afin qu'elles puissent s'attaquer aux déterminants de la santé, soulignant que les personnes qui vivent le plus près du problème se trouvent souvent le plus près de la solution. Le rapport précisait qu'il faut honorer et appuyer les collectivités afin qu'elles élaborent leurs propres solutions adaptées à la situation locale, à partir du fond existant de connaissances, d'expérience et d'énergie. Les interventions communautaires sont celles qui parviennent le mieux à rejoindre les

populations vulnérables, à créer des réseaux locaux et à tirer parti des ressources. De la même façon, dans un rapport publié en 2008, la Canada West Foundation soulignait que la seule solution à long terme pour régler les problèmes sociaux au niveau de la rue réside dans la prévention, et que celle-ci n'est possible que si les collectivités sont solides et inclusives²¹.

Les gouvernements s'initient à un nouveau rôle, celui de trouver la meilleure façon d'outiller et d'appuyer les collectivités afin qu'elles prennent les devants. De nombreuses recommandations contenues dans le présent rapport veulent favoriser l'adoption de ce nouveau rôle, et visent notamment la façon dont les données sont recueillies et mises en commun, le type de recherches nécessaires et leur mode de réalisation, ainsi que l'importance vitale d'une approche pangouvernementale. Mais pour que les efforts des collectivités portent fruit, il faut

Il n'y a pas que le gouvernement fédéral qui doit faire preuve de leadership — et je suis d'avis que le gouvernement fédéral a un rôle important à jouer —, mais le leadership doit venir du bas aussi. C'est ainsi que les choses vont fonctionner, et pas autrement.

*Debra Lynkowski, directrice générale,
Association canadienne de santé
publique, 18 avril 2008 (4:83).*

²⁰ Association canadienne pour la santé mentale, *mémoire au Sous-comité*, 2008, p. 5.

²¹ Canada West Foundation, *From the Ground Up: Community's Role in Addressing Street-Level Social Issues*, 2008, http://www.cwf.ca/V2/cnt/publication_200810271452.php.

également changer la façon dont les gouvernements créent les partenariats et appuient les initiatives.

3.1 Accroître les exigences en matière de rapports

Le succès de l'approche pangouvernementale décrite à la partie I pourra en grande partie se mesurer à l'aune de la capacité des collectivités de s'attaquer à des questions complexes au moyen de solutions intersectorielles intégrées appuyées par un éventail de ministères et d'organismes des différents ordres de gouvernement.

Étant donné que les programmes visant les déterminants de la santé relèvent de divers ministères, les initiatives qui reposent sur une approche intégrée pourraient être admissibles à des fonds provenant de sources multiples. Le rapport du Groupe d'experts indépendant sur les programmes de subventions et de contributions du gouvernement fédéral recommande la production de rapports qui répondent aux exigences redditionnelles de tous les programmes fédéraux visés, afin que le bénéficiaire de fonds provenant de divers programmes puisse regrouper les rapports²². Il faudra peut-être pour cela adopter des modifications législatives pouvant préciser certaines notions de responsabilité ministérielle, mais le Conseil du Trésor sera dès lors à même d'adopter une approche holistique, adaptée et coordonnée à l'égard des investissements dans la collectivité.

De la même façon, les trois ordres de gouvernement ont compétence sur les questions de déterminants de la santé. Pour cette raison, le Groupe d'experts indépendant a aussi recommandé dans son rapport que le Conseil du Trésor et son secrétariat, en coopération avec d'autres ordres de gouvernement, harmonisent les exigences fédérales, provinciales et municipales en matière d'information, de rapport et de vérification

imposées en vue des subventions et contributions. En fondant les exigences en matière de rapport sur les instruments existants qui renforcent l'obligation de rendre des comptes non seulement aux gouvernements mais aussi à la clientèle principale de l'organisme (soit ses membres ou la collectivité), le fardeau administratif sera réduit et le leadership local, accru. On peut dire sans crainte de se tromper que la mise en œuvre des comptes communautaires d'un bout à l'autre du pays facilitera certainement l'harmonisation des exigences en matière de rapport et de vérification. Par conséquent, le Sous-comité recommande :

En réalité, les régimes de financement actuels et de responsabilisation freinent l'innovation.

*Katherine Scott, vice-présidente,
Recherche, Conseil canadien du
développement social, 12 mars 2009
(2:12).*

Que le Secrétariat du Conseil du Trésor du Canada examine et revoit les exigences en matière de rapports sur les subventions et contributions imposées par les ministères et organismes fédéraux afin de mieux coordonner la production de rapports, tant à l'horizontale qu'à la verticale.

²² Des lourdeurs administratives à des résultats clairs : Rapport du Groupe d'experts indépendant sur les programmes de subventions et de contributions du gouvernement fédéral, décembre 2006, http://www.brp-gde.ca/pdf/Report_on_Grant_and_Contribution_Programs_fr.pdf.

3.2 Financement à plus long terme

Il faut souvent attendre des années avant qu'une action visant les déterminants de la santé donne des résultats, soit améliorer l'état de santé ou réduire les disparités en santé. Le Sous-comité a entendu dire à maintes reprises que le financement de projets à court terme, en tant que principale source de revenus, affaiblit les organismes communautaires puisqu'il crée de l'insécurité et empêche la planification à long terme. Les ententes de financement pluriannuelles, prévoyant des crédits annuels du Parlement, assureraient plus de stabilité au secteur en plus de réduire les coûts de fonctionnement du gouvernement. Par conséquent, le Sous-comité recommande :

Que le Secrétariat du Conseil du Trésor du Canada favorise le financement sur plusieurs années des projets assortis d'échéanciers pluriannuels. De même, il faudrait encourager, le cas échéant, les organismes subventionnaires fédéraux à privilégier eux aussi un financement pluriannuel.

3.3 Données et recherche sur les collectivités

Le cadre des déterminants de la santé présenté dans le graphique 1 illustre à quel point la santé de la population est un objectif complexe et dynamique, échelonné sur une longue période. Une intervention qui donne des résultats dans une collectivité à un moment donné ne donnera peut-être pas les mêmes résultats dans une autre collectivité, ou au même endroit à un autre moment. Chaque situation est particulière, de sorte que les dirigeants locaux doivent s'inspirer des formules qui ont réussi ailleurs, les adapter à la réalité locale, les évaluer sans cesse et déterminer lesquelles sont utiles.

Pour suivre ce cycle – agir, évaluer, apprendre et adapter –, les dirigeants communautaires doivent avoir accès à des données locales. Ces données locales doivent être extrêmement pointues, jusqu'au niveau du quartier et du code postal. Une analyse des données au niveau du code postal ou du quartier peut révéler des écarts choquants entre divers secteurs; la différence dans l'espérance de vie de deux quartiers de Montréal illustrée dans le graphique 2 plus haut en est un exemple. D^r Cushman en a fourni un autre quand il a décrit les différences entre deux quartiers d'Ottawa, soit le Glebe et Dalhousie; malgré leur proximité, le premier compte parmi les plus riches quartiers d'Ottawa, le second parmi les plus pauvres. Puisque le revenu est un important déterminant de la santé, il n'est pas étonnant de constater que les cas de maladies cardiaques et de diabète sont de deux à quatre fois plus nombreux dans le quartier Dalhousie que dans le Glebe²³. Malheureusement, de nombreuses villes canadiennes présentent aussi des quartiers qui sont aux antipodes. Étant donné ces grandes différences, les interventions visant à améliorer la santé et à réduire les disparités en santé devront presque assurément être taillées sur mesure pour correspondre à la réalité de chaque quartier, mais il faudra pour cela disposer de données facilement accessibles, détaillées jusqu'au niveau du quartier, voire du code postal.

²³ D^r Robert Cushman, directeur général, Réseau local d'intégration des services de santé de Champlain, 1^{er} avril 2009 (:).

Voilà une autre des forces du modèle des comptes communautaires recommandé précédemment : il met les données entre les mains des décideurs locaux. Il a aussi le mérite de réunir à un endroit les données provenant d'un éventail de sources fédérales et provinciales et de présenter un tableau complet de la situation locale. Cependant, les données seules ne suffisent pas. Il faut également une capacité locale d'analyser et d'interpréter ces données afin de produire une information significative pouvant orienter la prise de décisions au sujet d'initiatives locales visant les déterminants de la santé. De plus, la recherche interventionnelle pouvant mettre au jour les caractéristiques essentielles des initiatives fructueuses (ou infructueuses) aidera à mieux comprendre ce qui fonctionne et facilitera le transfert et l'application des apprentissages dans de nouveaux contextes.

Mais il importe surtout que l'analyse de données et la recherche soient menées de façon à habiliter les collectivités et à renforcer les capacités locales en vue d'une intervention à long terme. Le financement de la recherche et de l'évaluation doit donc faire partie de toute entente de programme. Ce système d'apprentissage et d'action fondé sur les faits servira de fondement à l'amélioration de la santé de la population et à la réduction des disparités en santé. Par conséquent, le Sous-comité recommande :

Que le gouvernement du Canada intègre le soutien de la capacité locale d'analyse et d'évaluation aux programmes visant à améliorer la santé de la population et à réduire les disparités en santé.

Le gouvernement fédéral joue un rôle important par l'appui direct aux entreprises et aux organismes locaux. Au-delà d'une cinquantaine de ministères et d'organismes fédéraux consacrent chaque année près de 27 milliards de dollars à plus de 800 programmes de subventions et de contributions²⁴. Pourtant, les structures du financement gouvernemental, qui visent habituellement des questions très précises, ont tendance à fragmenter les stratégies communautaires, à isoler les populations cibles et à diviser les secteurs d'activité.

Plusieurs mesures ont été prises ces dernières années afin d'améliorer les rapports financiers et redditionnels entre le gouvernement fédéral et le secteur bénévole/sans but lucratif, notamment l'Initiative sur le secteur bénévole et communautaire, le Groupe de travail sur les investissements dans les collectivités et le Groupe d'experts indépendant sur les programmes de subventions et de contributions du gouvernement fédéral. Ces travaux ont permis de marquer des progrès, mais il reste encore beaucoup à faire. Deux changements fondamentaux s'imposent afin de renforcer la capacité communautaire et d'appuyer l'intervention des collectivités en matière de déterminants de la santé, soit accroître les exigences en matière de rapports et fournir du financement à plus long terme.

²⁴ Rapport du Groupe d'experts indépendant sur les programmes de subventions et de contributions du gouvernement fédéral, *op. cit.*

3.4 Coordonner ou intégrer les services à l'échelon communautaire : modèles communautaires qui fonctionnent

Parce que la santé de la population est un objectif complexe et dynamique, elle exige une action concertée à l'échelon local à l'égard de l'ensemble ou d'un bon nombre des déterminants de la santé pour obtenir une amélioration d'ensemble des résultats en santé. Une fois qu'elles ont en main l'information et l'analyse nécessaires pour bien cerner les difficultés et en faire le suivi, les collectivités doivent adopter une approche concertée et stratégique pour agir localement sur ces déterminants.

Le tissu social du Canada étant, par définition largement diversifié, les méthodes utilisées par les collectivités pour s'attaquer aux déterminants de la santé de façon concertée peuvent prendre de nombreuses formes. Le Sous-comité a été extrêmement impressionné en prenant connaissance du large éventail d'initiatives fructueuses mises en œuvre dans des contextes ruraux, urbains, autochtones et autres pour contribuer à la bonne santé, au bien-être, à la productivité et à la faible criminalité. Les nouvelles pratiques communautaires, comme le développement économique communautaire et l'économie sociale, permettent d'agir de façon concertée sur bon nombre des déterminants de la santé et aussi de donner aux citoyens les moyens de se prendre en main. Ces modes d'intervention locale et intégrée sont le fruit d'un savant dosage d'objectifs socio-économiques et environnementaux qui peuvent influencer positivement sur bon nombre des déterminants de la santé, surtout au sein des groupes marginalisés ou minoritaires. Ils prennent racine dans les collectivités elles-mêmes, s'appuient sur le travail de bénévoles et sont orientés par les citoyens. Quelques exemples valent la peine d'être mentionnés.

Pendant son séjour à Terre-Neuve-et-Labrador, le Sous-comité a eu le plaisir de visiter les Stella Burry Community Services et de prendre un savoureux dîner au restaurant Stella's Circle. Ces services viennent en aide aux adultes aux prises avec de graves problèmes sociaux et psychologiques. Ils offrent, par exemple, du soutien et du counselling aux personnes ayant vécu des problèmes personnels importants (abus, toxicomanie, violence et incarcération), mettent sur pied des projets de logement abordable pour des personnes et des familles à faible revenu et offrent des programmes de formation et de perfectionnement. Le Stella's Circle est une entreprise sociale lancée par les Stella Burry Community Services dans le but d'offrir des débouchés de travail et de formation dans l'industrie des services alimentaires, d'offrir des repas économiques aux membres de Stella Burry qui doivent avoir une bonne alimentation malgré un revenu limité et de constituer une source de revenus pour l'organisation. Grâce à ces deux initiatives, l'organisation Stella Burry peut agir de façon concertée sur beaucoup plus de déterminants de la santé auprès de la population qu'elle dessert.

Toujours pendant qu'il se trouvait à Terre-Neuve-et-Labrador, le Sous-comité a entendu parler de l'initiative Vibrant Communities de l'Institut Tamarack. Vibrant Communities est une démarche communautaire qui vise à faire reculer la pauvreté dans 15 villes canadiennes grâce au soutien de diverses initiatives locales de lutte à la pauvreté auxquelles participe le secteur privé et grâce auxquelles de nombreux déterminants de la santé peuvent être améliorés. À St. John's, l'un des projets mis en œuvre dans le cadre des Vibrant Communities est le Citizen's Voice Network, dont les intervenants se réunissent à intervalles réguliers pour échanger de

l'information, se renseigner et influencer collectivement l'élaboration des politiques et la prise de décisions.

Les conseils de planification sociale comme le Human Development Council à St. John, au Nouveau-Brunswick, contribuent eux aussi utilement en travaillant de concert avec les citoyens et en rapprochant les services communautaires pour améliorer la qualité de vie en général. Le Human Development Council intervient principalement de deux façons : il informe pour rapprocher les citoyens des services à la personne et il participe de façon proactive à la recherche de solutions aux défis qui se posent aux collectivités²⁵. Le rapport du Groupe d'étude du premier ministre du Nouveau-Brunswick sur le secteur communautaire sans but lucratif préconise à juste titre un décloisonnement des structures régionales au sein des organismes communautaires pour favoriser l'autonomie régionale en matière de prestation des services, offrir une plus grande souplesse et encourager l'adoption d'une approche intégrée à l'égard des problèmes individuels et communautaires²⁶.

Le Québec a un secteur communautaire dynamique et dispose d'un éventail de structures différentes qui aident à coordonner l'action locale. On y trouve près d'une cinquantaine de Corporations de développement communautaire, qui regroupent des organismes communautaires de différents secteurs afin de faciliter la formation, le partage d'information et l'appui à la recherche et à la mise en œuvre de solutions concertées aux problèmes sociaux locaux²⁷. Soucieuses de concilier localement les déterminants socio-économiques et environnementaux de la santé, les quatorze Corporations de développement économique communautaire aident les collectivités à trouver et à mettre en œuvre leurs propres solutions aux problèmes économiques grâce à la mobilisation des résidents, des entreprises et des institutions de la collectivité²⁸. Issu du mouvement Villes et Villages en santé, *Vivre Saint-Michel en santé* est un mouvement de concertation intersectorielle et multiréseaux qui réunit des citoyens, des organismes communautaires, des institutions, des gens d'affaires et des organismes gouvernementaux qui ont à cœur la revitalisation des quartiers de Montréal²⁹. *Vivre St-Michel en santé* a dirigé un processus de consultation, de planification et d'étude qui s'est échelonné sur une année. Quelque 400 membres et intervenants de la collectivité ont participé à cette initiative qui a débouché sur un vaste plan communautaire pour améliorer les conditions sociales et économiques.

En Ontario, la Learning Enrichment Foundation (LEF) est l'un des plus anciens et des plus gros organismes de développement économique communautaire du pays. Située dans une importante région d'accueil pour les immigrants qui arrivent à Toronto, la LEF a mis au point tout un éventail de programmes et de services dans le cadre de son approche holistique. Elle offre notamment des programmes de formation professionnelle dans les secteurs où il existe localement des possibilités d'emploi, des cours de formation linguistique et d'alphabétisation pour les nouveaux arrivants au Canada, 18 centres de la petite enfance, 16 services de garde avant ou après la classe, une cuisine où sont préparés 500 repas par jour pour les organismes œuvrant auprès des sans-abri, des entreprises de formation en ébénisterie et en services de

²⁵ <http://www.humandevlopmentcouncil.nb.ca/>.

²⁶ <http://www.gnb.ca/cnb/promos/nptf/index-f.asp>.

²⁷ <http://www.tncdc.qc.ca/openfile.aspx?ID=196>.

²⁸ <http://www.lescdcc.qc.ca/>.

²⁹ <http://www.vsmsante.qc.ca/site/index.asp?sortcode=1.1>.

restauration pour les jeunes à risque, un service de recrutement pour les employeurs, un service de dépannage en technologie, des points d'accès à des ordinateurs, un fonds de prêts à la formation, plusieurs entreprises sociales ainsi que de la formation et du soutien pour les travailleurs indépendants³⁰.

Le programme Quartiers vivants! au Manitoba est une stratégie de développement communautaire, social et économique à long terme qui vise à soutenir et encourager les efforts de revitalisation des quartiers dans un certain nombre de domaines clés comme la rénovation des logements et des bâtiments; l'emploi et la formation; l'éducation et les loisirs; la sécurité et la prévention du crime³¹. Par l'intermédiaire de sociétés de revitalisation de quartiers dirigées par des citoyens et d'un éventail d'autres programmes, Quartiers vivants! mise sur les points forts et l'expérience des résidents locaux pour bâtir des quartiers sains.

Fondée en 1995, la Quint Development Corporation de Saskatoon s'est donné pour mission de renforcer le bien-être économique et social de cinq quartiers centraux de Saskatoon par l'adoption d'une approche communautaire. Son conseil d'administration, qui est aux trois quarts composé de résidents, oriente le travail de l'organisme afin d'améliorer l'accès à des logements abordables, de soutenir le renouvellement des entreprises et d'offrir des possibilités de création d'emplois³². Au nombre des principales et des plus récentes initiatives de renouvellement des entreprises, mentionnons Station 20 West, qui est un centre entrepreneurial communautaire qui regroupera sous un même toit toute une panoplie d'entreprises, de services et d'organismes – allant d'une bibliothèque à des soins de santé et des soins dentaires en passant pas des magasins d'alimentation et d'outils domestiques. On espère que ce foyer communautaire agira comme catalyseur du renouveau économique et social des quartiers centraux de Saskatoon.

Le mouvement Communautés en santé est un autre modèle important. Il a vu le jour dans la foulée d'une conférence internationale tenue à Toronto en 1984 et compte actuellement des organismes dans plusieurs provinces, dont l'Ontario, le Québec et la Colombie-Britannique. Dans cette dernière, le BC Healthy Communities (BCHC) invite les administrations publiques et les organismes communautaires à coordonner les initiatives et les programmes d'un ministère et d'un secteur à l'autre pour s'attaquer aux déterminants de la santé. BCHC recourt aussi à l'animation communautaire, à des ateliers, à des trousseaux d'outils et à de petites subventions de démarrage pour aider les collectivités et les groupes communautaires à adopter une démarche holistique et intégrée à l'égard de l'amélioration de la santé et du bien-être.

Un domaine de connectivité qui mérite une attention particulière est le rôle local joué par le système de soins de santé. Les témoins qui ont comparu devant le Sous-comité et notre propre recherche comparative internationale ont confirmé que les services de santé les plus efficaces sont ceux qui reposent sur un solide système de soins de santé primaires, lié à un large éventail de services sanitaires et sociaux. Les programmes de prévention peuvent aussi avoir une profonde incidence sur l'amélioration de la santé et du bien-être et de l'accroissement de la productivité.

³⁰ http://lefca.org/index.php?option=com_content&task=view&id=1.

³¹ <http://www.gov.mb.ca/ia/programs/neighbourhoods/index.fr.html>.

³² <http://www.quintsaskatoon.ca/aboutquint.html>.

Les médecins et les responsables locaux de la santé publique peuvent jouer un rôle de chef de file en faisant en sorte que le public comprenne mieux le lien existant entre les déterminants de la santé et la santé de la population, et en facilitant l'établissement de la collaboration nécessaire au niveau local pour s'attaquer aux déterminants de la santé. À cet égard, le rapport sur les disparités en santé préparé en 2008 par la Saskatoon Health Region est un exemple remarquable³³. La Saskatoon Health Region a réuni des preuves accablantes mais solides de l'existence dans la ville de disparités en santé, et a ensuite tenu au-delà de 200 séances de consultation communautaire en présence de représentants gouvernementaux, d'universitaires et de groupes communautaires au sujet de ces preuves. Les auteurs du rapport proposent un ensemble complet et coordonné de solutions possibles fondées sur des preuves, qui n'est pas loin de faire l'unanimité à en juger par les revues de presse internationales, par les échos de la deuxième ronde de consultation tenue dans plus d'une centaine de collectivités et par les résultats d'un sondage téléphonique réalisé auprès de 5 000 résidents de Saskatoon.

Nous devons mettre davantage l'accent sur les soins de santé que sur les hôpitaux. Ce que je veux que vous sachiez est que la collectivité ne dispose pas de ressources suffisantes. Nous devons mettre davantage l'accent sur la collectivité que sur les institutions.

D' Robert Cushman, directeur général, Réseau local d'intégration des services de santé de Champlain, 1^{er} avril 2009 (:).

Le réseau de CLSC au Québec et les centres de santé communautaires dans d'autres provinces montrent comment il est possible de réunir un éventail de services sous un même toit, dans des centres de quartier. Notre examen du modèle de polyclinique à Cuba a dissipé tout doute concernant ce qui peut être accompli au moyen de budgets très modestes, grâce à une solide présence de soins primaires ancrés dans la vie de quartier, qui s'attaquent simultanément à de nombreux déterminants de la santé. Les polycliniques cubaines sont multidisciplinaires et assurent l'intégration de la science, le transfert des connaissances, l'éducation des parents et des grands-parents et la mobilisation de la collectivité, dans le cadre d'un solide système de soins de santé primaires multidisciplinaire. Leur mandat étant axé sur la prévention, elles entreprennent régulièrement des projets de dépistage universel et recommandent fortement l'immunisation. Elles servent en outre à la formation médicale et pédagogique – les étudiants en médecine et en nursing reçoivent l'essentiel de leur formation dans des polycliniques, souvent dans celle où ils seront professionnellement rattachés une fois leurs études terminées. De plus, dans le cadre d'une approche communautaire intégrée, le personnel des polycliniques travaille en étroite collaboration avec les enseignants des centres de développement de la petite enfance, des centres préscolaires et des écoles primaires. Il tient des réunions périodiques (semestrielles) afin de discuter de la santé mentale et physique générale des enfants de la collectivité. Les conseils de quartier veillent à ce que les services, comme les programmes d'enseignement préscolaire, soient adaptés aux besoins de la collectivité.

L'intégration ou la coordination des services à l'échelon local peut aider à rationaliser et à simplifier l'accès, à accroître l'efficacité et à faire le pont avec les programmes conventionnels. Mais en définitive, l'intégration est un processus, et il n'existe pas de modèle unique pouvant s'appliquer à toutes les situations. Il s'agit plutôt d'un objectif qui doit être adapté à chaque

³³ http://www.saskatoonhealthregion.ca/your_health_documents/PHO_HealthDisparityRept-complete.pdf.

contexte communautaire. L'important est de mettre l'accent sur des mesures concertées axées sur les besoins locaux.

À l'échelle internationale, le Canada traîne derrière les autres instances à cet égard. Nous pouvons tirer des enseignements de nos propres exemples de réussite et de ceux d'autres pays, notamment la Suède et le Royaume-Uni, afin de trouver la meilleure combinaison de modèles de responsabilité relevant des instances décisionnelles tant supérieures que locales, mettant en équilibre la souplesse locale et la responsabilité nationale. Par conséquent, le Sous-comité recommande :

Que le gouvernement du Canada travaille en collaboration avec les autres ordres de gouvernement et le secteur non gouvernemental afin d'appuyer l'intégration ou la coordination de services communautaires dans un cadre de déterminants de la santé.

4. LA SANTÉ DE LA POPULATION AUTOCHTONE

Les communautés autochtones recèlent une richesse extraordinaire de potentiel non exploitée dont le gouvernement du Canada pourrait appuyer l'épanouissement³⁴.

À l'heure actuelle, les Autochtones canadiens – les Premières nations, les Inuits et les Métis – présentent tous un état de santé bien inférieur à la moyenne nationale. Selon les témoignages recueillis par le Sous-comité, les Autochtones au Canada vivent une situation d'inégalité. Les disparités sont frappantes entre les Canadiens autochtones et les Canadiens non autochtones pour la plupart des déterminants de la santé, et les écarts se creusent. Soulignons en particulier les conditions socioéconomiques dans lesquelles vivent les peuples autochtones, souvent comparées à celles de pays en développement. La situation est non seulement déplorable, elle est tout simplement inacceptable.

Dans le passé, les peuples autochtones n'ont pas été les participants à part entière de l'État nation qu'est le Canada, et la situation est encore la même aujourd'hui. Avec l'évolution de l'économie politique du Canada, il est devenu nécessaire de déplacer les peuples autochtones de leurs terres ancestrales et de modifier leur mode de vie pour faire place aux sociétés colonisatrices. Il ne s'agit pas de mon opinion; c'est une question de fait. Le processus de dislocation qui a découlé de la colonisation a engendré l'exclusion sociale du reste du Canada d'un grand nombre de peuples et de collectivités autochtones. Cette exclusion a conduit à la marginalisation sur les plans de l'éducation, de l'emploi, du logement, des soins de santé et de nombreux autres services. Cela a ensuite créé une société à deux classes au Canada – ça a créé une norme pour les Canadiens en général et une autre pour les peuples autochtones.

Jeff Reading, professeur et directeur, Centre de recherche sur la santé des Autochtones, 26 mars 2009 (3:12-13).

³⁴ Conference Board of Canada's Roundtable on the Socio-Economic Determinants of Health, *op. cit.*, p. 14.

Le Sous-comité reconnaît les intérêts particuliers et les besoins propres de chaque groupe autochtone – Premières nations, Inuits et Métis. Nous pensons aussi, comme les témoins, qu'il faut inclure tous les peuples autochtones, qu'ils habitent dans les réserves ou les peuplements, en milieu rural ou urbain, dans les régions septentrionales ou arctiques. L'approche que propose le Sous-comité en matière de santé de la population, axée sur le niveau communautaire, donne la souplesse nécessaire pour améliorer la santé et le bien-être des Autochtones tout en respectant les distinctions sociales, culturelles et locales. Nous sommes d'accord avec les témoins qui ont souvent déclaré que les groupes n'entrent pas tous dans le même moule. Nous sommes aussi fermement convaincus, comme de nombreux témoins, que même les collectivités les plus défavorisées disposent parfois de forces, de capacités et d'atouts importants et étonnants qui peuvent servir à améliorer leur santé physique et mentale et leur bien-être. Les perspectives autochtones en matière de santé et de bien-être offrent des modèles holistiques féconds. Les groupes inuits et métis présentent chacun leur propre vision et schéma du bien-être holistique, qui ont beaucoup d'éléments en commun avec le cadre illustré dans le graphique 1 qui précède. Étant donné l'importance fondamentale de respecter les distinctions sociales, culturelles et locales dans les politiques et programmes de la santé destinés aux peuples autochtones, le Sous-comité recommande :

Que les peuples autochtones – Premières nations, Inuits et Métis – participent à la conception, à l'élaboration et à la prestation des programmes et des services fédéraux visant les déterminants de la santé dans leurs collectivités respectives.

Le Sous-comité sait que plus de 30 ministères et organismes fédéraux offrent actuellement quelque 360 programmes et services fédéraux aux peuples et aux collectivités autochtones. Ces programmes et services visent la santé, l'éducation permanente, les collectivités sûres et durables, le logement, les possibilités économiques, les terres et les ressources et les liens de gouvernance. Le Sous-comité abonde dans le sens de nombreux témoins qui estiment que ces programmes et services pourraient être mieux coordonnés et intégrés afin de viser les déterminants de la santé chez la population autochtone. Une approche pangouvernementale, où 30 ministères et organismes travailleraient ensemble de façon intégrée, constituerait une première étape vers la réduction des disparités en santé entre Canadiens autochtones et Canadiens non autochtones. Actuellement, le fonctionnement en vase clos au fédéral empêche les collectivités autochtones d'élaborer, à leur propre rythme et selon leurs besoins, une approche complète à l'égard des déterminants de la santé. Les instances décisionnelles supérieures devront prendre les rênes afin d'éliminer ces vases clos. De plus, une approche axée sur la santé de la population va tout à fait dans le sens de la croyance autochtone voulant que la santé aille de pair avec l'atteinte de l'équilibre dans tous les aspects de la vie : spirituel, mental, émotionnel, physique et social.

Dans la conception inuite du monde, la santé, l'éducation et les conditions sociales sont toutes interreliées. C'est vraiment une difficulté lorsqu'il y a des ministères qui travaillent de manière fortement cloisonnée. (...) Pour les Inuits, c'est un réel défi de travailler avec un système qui fonctionne en vase clos.

Rosemary Cooper, directrice des services à la haute direction, Inuit Tapiriit Kanatami, 25 mars 2009 (2:41).

Des témoins ont fait valoir qu'après avoir présenté des excuses officielles aux « générations volées » en 2008, le premier ministre australien a pris les devants et mis en œuvre un programme afin de combler l'écart qui défavorise les aborigènes. La nouvelle approche repose à la fois sur l'injection de fonds nouveaux et sur la réorientation des fonds. Le projet Comblant l'écart conjugue une approche pangouvernementale à l'échelon du Commonwealth – le Comité du Cabinet sur les affaires aborigènes – et un mécanisme intergouvernemental – la coopération avec les États et les territoires – par l'intermédiaire du Conseil des gouvernements d'Australie (CGA). Tous les gouvernements ensemble ont élaboré et adopté six cibles principales touchant l'espérance de vie chez les Autochtones, le taux de mortalité, la littératie et la numératie, l'emploi, la scolarisation et la petite enfance.

Le premier ministre australien a fait une déclaration il y a un an sur le besoin de combler l'écart. En Australie, on s'efforce à l'échelle nationale de combler l'écart entre l'état de santé des peuples aborigènes et celui de la population dans son ensemble. Durant la première journée où siège le Parlement chaque année, le premier ministre présente un rapport au Parlement sur les progrès de l'ensemble du gouvernement pour combler l'écart.

*Jeff Reading, professeur et directeur,
Centre de recherche sur la santé des
Autochtones, 26 mars 2009 (3:31).*

Au Canada, le premier ministre, dans les excuses qu'il a présentées aux anciens élèves des pensionnats indiens au nom de la population canadienne, a souligné qu'il s'agissait de prendre un nouveau départ et d'aller de l'avant en partenariat. Le Sous-comité estime qu'il est temps maintenant pour le gouvernement fédéral d'agir. Il est essentiel de réduire, d'éliminer même les disparités troublantes entre les Canadiens autochtones et les Canadiens non autochtones pour pouvoir améliorer la santé et les conditions socioéconomiques des Premières nations, des Inuits et des Métis. L'approche adoptée en Australie constitue un très bon modèle pour le Canada. De plus, nombre d'éléments sont déjà en place afin que le programme puisse être réalisé.

Le 11 juin marquera le premier anniversaire des excuses émises par le Parlement du Canada aux anciens pensionnaires. Les excuses n'ont pas seulement reconnu les erreurs du passé, elles ont également laissé entendre de profonds changements. L'heure est venue de changer fondamentalement les systèmes de soins de santé et d'en arriver à une équité réelle. Mes enfants ainsi que les vôtres ne méritent rien de moins.

*Bob Watts, directeur exécutif,
Assemblée des Premières nations,
25 mars 2009 (2:32).*

En 2005, un processus baptisé la Table ronde Canada-Autochtones a donné lieu à un ensemble d'ententes entre les dirigeants autochtones et les gouvernements canadiens concernant les niveaux de vie et les droits de la personne fondamentaux. Il a permis d'établir des objectifs et d'attribuer des fonds afin de réduire les disparités entre les communautés autochtones et l'ensemble de la population canadienne. Jamais auparavant n'a-t-on été témoin d'un degré d'implication aussi élevé de la part de dirigeants des gouvernements fédéral, provinciaux et territoriaux ainsi que des dirigeants, collectivités et organismes autochtones. Ont participé aux négociations l'Inuit Tapiriit Kanatami (représentant les Inuits); le Ralliement national des Métis (représentant les Métis); l'Assemblée des Premières Nations (représentant les Premières nations); le Congrès des peuples autochtones (représentant les peuples autochtones vivant en milieu urbain ou hors réserve); et l'Association des femmes autochtones du Canada (représentant les femmes autochtones). Le Sous-comité estime que le Canada doit prendre appui sur cette réalisation historique et, par conséquent, il recommande :

Dans les excuses qu'il a présentées au nom du Canada aux victimes des pensionnats indiens, le premier ministre a déclaré qu'il s'agit d'un nouveau départ, une occasion d'aller de l'avant de concert. Nous attendons toujours qu'il se passe quelque chose de ce côté-là. Nous croyons que le moment est venu pour le gouvernement fédéral d'agir.

*Rose Sones, directrice adjointe,
Politiques stratégiques, Secrétariat à
la santé et au développement social,
Assemblée des Premières Nations,
25 mars 2009 (2:53).*

Que le premier ministre du Canada, dans un premier pas vers l'élaboration et la mise en œuvre d'une stratégie sur la santé de la population pancanadienne, travaille de concert avec les premiers ministres des provinces et des territoires, ainsi qu'avec les dirigeants des Premières nations, des Inuits, des Métis et des autres peuples autochtones, afin de combler l'écart quant aux résultats en santé des Canadiens autochtones, au moyen de programmes et de services exhaustifs, holistiques et coordonnés.

Que la priorité soit accordée aux déterminants de la santé suivants : de l'eau propre, la salubrité des aliments, le rôle parental et l'apprentissage de la petite enfance, l'éducation, le logement, le développement économique, les soins de santé et la violence faite aux femmes, aux enfants et aux aînés autochtones.

De nombreux représentants autochtones ont dit au Sous-comité à quel point les conflits de compétences à propos du financement et de la prestation des programmes retardent l'accès au programme et l'obtention d'un soutien. Dans ce contexte, ils ont raconté l'histoire de Jordan River Anderson, un enfant des Premières Nations, né avec de graves problèmes de santé. Sa famille, qui ne disposait pas de moyens nécessaires pour prendre soin de lui à la maison, a pris la difficile décision de le placer dans un établissement pédiatrique hors réserve peu après sa naissance. Jordan est demeuré hospitalisé pendant les deux premières années de sa vie, le temps que son état de santé se stabilise. Peu après son deuxième anniversaire, les médecins ont dit qu'il pouvait être ramené au domicile familial. Malheureusement, les gouvernements fédéral et provincial ont commencé à se disputer pour savoir quel ordre de gouvernement et quel ministère

devaient payer pour les soins à domicile de Jordan! Ce conflit de compétences a duré deux ans et a eu pour conséquence de retenir inutilement Jordan à l'hôpital. Malheureusement, le bambin est décédé avant que le conflit de compétences ne se règle. C'est pour honorer sa mémoire qu'on a énoncé le principe de Jordan. Ce principe axé sur « l'enfant d'abord » vise à faire en sorte que les services nécessaires à un enfant ne soient pas retardés ou perturbés par des conflits de compétences. En décembre 2007, le gouvernement fédéral a approuvé le principe de Jordan en adoptant la motion d'initiative parlementaire n° 296. Cette politique historique qui fait passer « l'enfant d'abord » doit toutefois être approuvée par tous les ordres de gouvernement avant de pouvoir être mise en application. De plus, le Sous-comité convient avec les témoins que ce principe devrait s'appliquer à tous les Canadiens autochtones, sans égard à l'âge, parce que ceux-ci « passent entre les mailles du filet » dans bien des domaines où la compétence fédérale et les responsabilités provinciales et territoriales se chevauchent. Par conséquent, le Sous-comité recommande :

Que le gouvernement du Canada s'entende avec les provinces et les territoires pour appliquer le principe de Jordan à tous les programmes, mesures et services portant sur les déterminants de la santé des Autochtones de tous les groupes d'âge.

Le Sous-comité s'est aussi fait dire à maintes reprises que la vision qu'ont les Autochtones de la santé physique et mentale et du bien-être est ancrée dans le cercle sacré et fait ressortir l'importance de l'autodétermination. Certains témoins sont d'avis que bien des collectivités autochtones pourraient adapter le modèle cubain des polycliniques pour offrir des services et des programmes intégrés en ce qui concerne la santé de la population. D'autres ont souligné que la création de conseils communautaires autochtones dotés de structures semblables, à certains égards, à celles des régies régionales de la santé aiderait à donner suite au désir légitime des peuples autochtones de jouir de l'autodétermination dans le domaine de la santé de la population. D'autres témoins, par contre, ont indiqué que certaines collectivités autochtones disposent déjà des structures et des mécanismes nécessaires pour faciliter l'élaboration et l'application d'une politique sur la santé de la population. Par conséquent, le Sous-comité recommande :

Que le gouvernement du Canada, de concert avec ses homologues provinciaux et territoriaux ainsi qu'avec les organismes des Premières nations, inuits et métis compétents, appuie et finance la mise en place d'un bout à l'autre du pays des structures et mécanismes nécessaires pour faciliter l'élaboration et la mise en œuvre de programmes holistiques complets et coordonnés de nature à remédier aux disparités en santé dans les collectivités autochtones.

CONCLUSION

Le Canada a été un chef de file mondial pour ce qui est d'améliorer la compréhension de la santé de la population et des disparités en santé. En 1974, le rapport Lalonde a complètement transformé la façon de voir la santé, une nouvelle vision qu'ont amplifiée en 1986 la Charte d'Ottawa pour la promotion de la santé et le rapport Epp. L'Institut canadien de recherches avancées, par l'intermédiaire de son Programme de la santé des populations et de publications comme *Why Are Some People Healthy and Others Are Not?* (Pourquoi certaines personnes sont-elles en bonne santé alors que d'autres ne le sont pas), a donné lieu à une meilleure compréhension des déterminants de la santé et des disparités en santé. Cependant, au cours des dernières années, l'élaboration des politiques n'a pas suivi l'état de ces connaissances, car le coût et la prestation des soins de santé ont dominé le dialogue public. En fait, le Canada accuse maintenant du retard par rapport à des pays comme le Royaume-Uni et la Suède en ce qui concerne l'application du fond de connaissance sur la santé publique qui a pourtant été largement élaboré dans notre pays.

Le manque d'action s'est traduit par un accroissement des disparités en santé au Canada. Le Sous-comité juge inacceptable pour un pays riche comme le nôtre de continuer de tolérer de telles disparités. Nous craignons que la pénible conjoncture économique, sans précédent pour ses répercussions mondiales, ne fasse qu'accroître ces disparités. C'est pour ces raisons que nous proposons un ensemble de recommandations visant à améliorer la santé de tous les Canadiens et en particulier de nos groupes les plus défavorisés – les Premières nations, les Inuits et les Métis. Notre projet, qui met l'accent sur le cycle de vie, conjugué à une approche communautaire, peut déboucher sur des gains extraordinaires sur le plan de la santé, de la productivité et de la richesse. C'est possible si tous les gouvernements agissent ensemble de façon stratégique et coordonnée sur les déterminants de la santé, pour mobiliser les collectivités, le secteur des entreprises et toute la population canadienne afin de promouvoir une vision d'un avenir sain, juste et florissant. Sous la direction du premier ministre du Canada, nous pouvons, ensemble, améliorer la santé et accroître la richesse au cours de la prochaine génération.



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WITNESSES

Wednesday, April 1st, 2009

Champlain Local Health Integration Network:

Dr. Robert Cushman, Chief Executive Officer.

BC Healthy Communities:

Jodi Mucha, Director.

As an individual:

Dr. Kellie Leitch.

TÉMOINS

Le mercredi 1^{er} avril 2009

Réseau local d'intégration des services de santé de Champlain :

Dr Robert Cushman, directeur général.

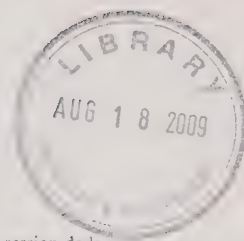
BC Healthy Communities :

Jodi Mucha, directrice.

À titre personnel :

Dre Kellie Leitch.





Second Session
Fortieth Parliament, 2009

Deuxième session de la
quarantième législature, 2009

SENATE OF CANADA

SÉNAT DU CANADA

*Standing Senate Committee on Social Affairs,
Science and Technology*

*Comité sénatorial permanent des Affaires sociales,
des sciences et de la technologie*

Proceedings of the Subcommittee on

Délibérations du Sous-comité sur la

Population Health

Santé des populations

Chair:

The Honourable WILBERT J. KEON

Président :

L'honorable WILBERT J. KEON

Wednesday, April 1, 2009
Thursday, May 7, 2009 (in camera)
Wednesday, May 27, 2009 (in camera)

Le mercredi 1^{er} avril 2009
Le jeudi 7 mai 2009 (à huis clos)
Le mercredi 27 mai 2009 (à huis clos)

**Issue No. 4
(Volume 2 of 3)**

**Fascicule n° 4
(Volume 2 de 3)**

**Ninth, tenth and eleventh (last)
meetings on:**

The impact of the multiple factors and conditions that
contribute to the health of Canada's populations —
known collectively as the determinants of health

**Neuvième, dixième et onzième (dernière)
réunions concernant :**

Les divers facteurs et situations qui contribuent
à la santé de la population canadienne, appelés
collectivement les déterminants de la santé

INCLUDING:
THE SECOND REPORT OF THE SUBCOMMITTEE
(*A Healthy, Productive Canada:
A Determinant of Health Approach*)
(Appendix A)
(Eighth Report of Standing Senate Committee on Social
Affairs, Science and Technology)

Y COMPRIS :
LE DEUXIÈME RAPPORT DU SOUS-COMITÉ
(*Un Canada en santé et productif :
une approche axée sur les déterminants de la santé*)
(Annexe A)
(Le huitième rapport du Comité sénatorial permanent des
Affaires sociales, des sciences et de la technologie)

WITNESSES:
(*See back cover*)

TÉMOINS :
(*Voir à l'endos*)

THE SUBCOMMITTEE ON POPULATION HEALTH

The Honourable Wilbert J. Keon, *Chair*

The Honourable Lucie Pépin, *Deputy Chair*

and

The Honourable Senators:

Callbeck
Champagne, P.C.
Cook

Eaton
Fairbairn, P.C.

(Quorum 3)

Changes in membership of the subcommittee:

Pursuant to rule 85(4), membership of the subcommittee was amended as follows:

The Honourable Senator Champagne, P.C., replaced the Honourable Senator Stratton (*March 30, 2009*).

The Honourable Senator Stratton replaced the Honourable Senator Champagne, P.C. (*March 27, 2009*).

LE SOUS-COMITÉ SUR LA SANTÉ DES POPULATIONS

Président : L'honorable Wilbert J. Keon

Vice-présidente : L'honorable Lucie Pépin

et

Les honorables sénateurs :

Callbeck
Champagne, C.P.
Cook

Cook
Fairbairn, C.P.

(Quorum 3)

Modifications de la composition du sous-comité :

Conformément à l'article 85(4) du Règlement, la liste des membres du sous-comité est modifiée, ainsi qu'il suit :

L'honorable sénateur Champagne, C.P., a remplacé l'honorable sénateur Stratton (*le 30 mars 2009*).

L'honorable sénateur Stratton a remplacé l'honorable sénateur Champagne, C.P. (*le 27 mars 2009*).

A Life Course Approach to the Social Determinants of Health for Aboriginal Peoples'

Jeff Reading PhD

for

The Senate Sub-Committee on Population Health

March 2009

TABLE OF CONTENTS

SYNTHESIS	A-1
END POVERTY NOW	A-1
ACTIONS	A-3
THE BURDEN OF CHRONIC DISEASES AMONG ABORIGINAL PEOPLES IN CANADA	A-4
1.INTRODUCTION.....	A-4
2. THE BURDEN OF DIABETES IN ABORIGINAL POPULATIONS.....	A-4
2.1 DEFINITION OF DIABETES AND IMPAIRED GLUCOSE TOLERANCE	A-4
2.2 BURDEN OF TYPE 2 DIABETES IN ABORIGINAL POPULATIONS.....	A-4
2.3 UNDERSTANDING THE NUMBERS NOW AND IN THE FUTURE.....	A-7
3. THE BURDEN OF CARDIOVASCULAR DISEASE IN ABORIGINAL POPULATIONS.....	A-8
3.1 DEFINITION AND DESCRIPTION OF CARDIOVASCULAR DISEASE...A-8	
3.2 BURDEN OF CARDIOVASCULAR DISEASE IN ABORIGINAL POPULATIONS.....	A-9
THE BURDEN OF CHRONIC RESPIRATORY DISEASES IN ABORIGINAL POPULATIONS.....	A-10
4.1 DEFINITION AND DESCRIPTION OF CHRONIC RESPIRATORY DISEASES	A-10
4.2 GENERAL BURDEN OF CHRONIC RESPIRATORY DISEASE IN ABORIGINAL POPULATIONS	A-11
4.3 TUBERCULOSIS	A-11
4.4 CHRONIC OTITIS MEDIA.....	A-13
4.5 CHRONIC/RECURRING RESPIRATORY TRACT INFECTIONS	A-14
4.6 CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) AND ASTHMA.....	A-16
5. THE BURDEN OF MUSCULOSKELETAL CONDITIONS IN ABORIGINAL POPULATIONS.....	A-17
5.1 DEFINITION AND DESCRIPTION OF MUSCULOSKELETAL DISEASE AND DISORDERS	A-17
5.2 BURDEN OF ARTHRITIS IN ABORIGINAL POPULATIONS	A-18
5.3 OSTEOPOROSIS	A-20
6. THE BURDEN OF CANCER IN ABORIGINAL POPULATIONS	A-21

6.1 DEFINITION AND DESCRIPTION OF CANCER	A-21
6.2 CANCER SURVEILLANCE IN ABORIGINAL POPULATIONS	A-21
6.3 BURDEN OF CANCER IN ABORIGINAL POPULATIONS	A-22
PROVINCE	A-23
RELATED LITERATURE	A-23
7. BURDEN OF SEVERE MENTAL ILLNESS IN ABORIGINAL POPULATIONS.....	A-26
7.1 DEFINITION AND DESCRIPTION OF CHRONIC MENTAL ILLNESS .A-26	
7.2 BURDEN OF SEVERE MENTAL ILLNESSES IN ABORIGINAL POPULATIONS.....	A-27
7.3 BURDEN OF SEVERE MENTAL ILLNESSES ON COMMUNITY HEALTH	A-33
8. THE IMPACT OF CHRONIC DISEASES ON MENTAL HEALTH	A-34
8.1 DEFINING THE PARAMETERS OF THE ASSOCIATION BETWEEN CHRONIC DISEASE AND MENTAL HEALTH.....	A-34
8.2 UNPACKING THE ASSOCIATION BETWEEN CHRONIC DISEASE AND MENTAL HEALTH.....	A-37
8.3 COMMON THEMES.....	A-45
8.4 CO-MORBIDITY	A-50
8.4.1 CANCER AND DIABETES	A-50
8.4.2 DIABETES AND CVD	A-51
8.4.3 OSTEOPOROSIS AND CHRONIC DISEASES.....	A-51
8.4.4 HEALTH IMBALANCE AND CO-MORBIDITY	A-51
A LIFE COURSE APPROACH: CHRONIC DISEASE RISK FACTORS IN ABORIGINAL POPULATIONS IN CANADA.....	A-53
1. INTRODUCTION: TAKING A LIFE COURSE APPROACH	A-53
1.1 THE LIFE COURSE PERSPECTIVE AND ABORIGINAL HEALTH	A-54
1.2 APPLYING THE LIFE COURSE APPROACH.....	A-55
2. COMMUNITY RISK FACTORS	A-55
2.1 SOCIOECONOMIC RISK FACTORS.....	A-56
MENTAL HEALTH DIAGNOSIS	A-63
2.2 GEOGRAPHIC RISK FACTORS.....	A-66
3. PRENATAL RISK FACTORS.....	A-73
3.1 MATERNAL DIABETES	A-73

3.2 MATERNAL OBESITY	A-73
3.3 MATERNAL SMOKING	A-74
3.4 MATERNAL ALCOHOL USE	A-76
4. NATAL RISK FACTORS.....	A-77
4.1 ABNORMAL BIRTH WEIGHTS.....	A-78
4.2 BREASTFEEDING	A-79
5. EARLY CHILDHOOD RISK FACTORS	A-81
5.1 POPULATION INFLUENCES	A-81
5.2 CHILD POVERTY AND HUNGER.....	A-82
5.4 PARENTAL SMOKING AND HOUSEHOLD SMOKE	A-86
6. CHILDHOOD AND ADOLESCENT RISK FACTORS	A-87
6.1 CHILDHOOD OBESITY	A-87
6.2 SMOKING.....	A-88
6.3 SEXUAL HEALTH	A-91
6.5 ABORIGINAL CHILD WELFARE	A-97
7. ADULthood AND THE ELDERLY RISK FACTORS.....	A-100
7.1 SMOKING.....	A-100
7.2 ALCOHOL ABUSE.....	A-101
7.4 EMPLOYMENT AND EDUCATION.....	A-103
7.5 ELDER HEALTH.....	A-104

Synthesis

That population level factors which determine the health and well being for any collectivity have their origins is upstream historic, cultural, social, economic and political forces affecting the lives of Aboriginal Peoples' living in Canada, has been articulated for almost two decades.

Many determinants of health for Aboriginal peoples' are beyond the scope of the health care delivery system to provide such as: changing diets from traditional to non-traditional foods, food insecurity, stress due to economic factors, pollution and environmental degradation, global capitalism and others.

It is important to understand that words and their interpretation are very important in the discourse on determinants of health especially if the aim is to better understand the causes. Aboriginal Peoples' historically and to the present day, have not been full participants in the nation state called Canada. As the political economy of Canada evolved it became necessary to dislocate Aboriginal peoples' from their traditional lands in order to make way for settler societies. The process of dislocation as a result of colonization rendered many Aboriginal people and communities as socially excluded from the rest of Canada. The social exclusion led to marginalization in education, employment, housing, health care and many other services which effectively created a two-tiered society in Canada; one standard for Canadians and the other for Aboriginal Peoples'.

As difficult as this is to accept, there exists a plethora of evidence contained in this paper which proves that the Aboriginal experience in Canada is unequal. Aboriginal Peoples' experience greater health risk in almost every category measured which, in turn, leads to profound disparity for Aboriginal peoples especially the most vulnerable; namely, children and the elderly.

The social determinants are often referred to as the "causes of the causes". This means that disease, disability and death are influenced by individual risk factors such as smoking, obesity, substance abuse etc. Such risk factors have been criticized as blaming the victim as it is now understood that risk factors are socially embedded in the collective lives of individuals, families, communities, regions and nation states. Thus, disparities in the social determinants require social remedies.

End Poverty Now

Poverty eradication is the most important determinant of health, because it is through income that other determinants of health are purchased, such as adequate housing, access to health care services and education, potable water and nutritious foods etc.

In a recent report written by Drs. Charlotte Loppie Reading and Fred Wein (2009), commissioned by the Public Health Agency National Collaborating Centre for Aboriginal Health; Aboriginal Peoples experience health disparities that are simply not explained or understood using mainstream templates for what determines Aboriginal health. For example, when Aboriginal peoples' living off reserve were compared to non-Aboriginal peers, both groups

in urban settings and at comparable levels of low income; the Aboriginal group experienced significantly more major depressive episodes 21% versus 13% for their non-Aboriginal counterparts (Loppie Reading & Wien, 2009). There is something more than income and geography at play in this scenario. Interestingly, as income comparisons went from low to high for both groups, so to did the gradient in depressive symptoms which was reduced to statistical insignificance at the highest income level (Loppie Reading & Wien, 2009).

To explore the origins of health for Aboriginal Peoples', the unique context includes the socio-political factors, a holistic perspective of health with health optimization at each stage of the life course, from preconception to death.

Determinants were partitioned into 'proximal' factors including health behaviours, physical environments, employment and income, education and food insecurity. 'Intermediate' determinants were described as upstream to proximal and include systems of health care, education, community infrastructure, resources and capacities, environmental stewardship and cultural continuity. Finally, Loppie Reading and Wein (2009) discuss the most distal determinants including colonialism, racism, social exclusion and the need to *pursue self determination as a step toward population recovery*.

The goal is to optimize the developmental trajectory over the entire life course. The object is to address the complex interaction of health determinants across the dimensions of context and history which has led to modern day circumstances, in particular Aboriginal contexts, over the life course.

The proposal is for a community based population health model that would address the health determinants, facilitate and compliment a whole of government approach to Aboriginal population health at the Federal level. The model would need to *create a strategic alliance to connect the health determinants*.

According to the third report of the committee, over 30 Federal departments and agencies are delivering over 360 programs and services for Aboriginal peoples with more than half (190) available to all groups and the remainder available to particular groups (The Senate Subcommittee on Population Health, 2008). The 6 core areas for the proposed strategic alliance proposed here include education, community prevention and intervention, a special focus on mental health, housing, economic development and capacity investments to build a cadre of health professionals at all levels in development of a comprehensive Aboriginal health workforce.

Given that some 50% of the Aboriginal population is under age 25 years, it is logical to invest heavily in the health of the future generation while not ignoring the needs of the present. During early life from pre-conception health of the mother to the pre-natal and post natal periods; life is almost totally dependent on the mother. Whereas malleability of the infant/child is greatest in the earliest stages of life, spending on health, education and general well-being is inverse with the least amount spent in early life and the greatest investments made at the end of life.

The Regional Health Survey found that the social support and well-being of children is directly affected by the socio-economic status and educational attainment of their parents (First Nations Centre, 2005). Thus, education of children is one of the most obvious solutions. Longitudinal follow-up studies of 'Headstart' early childhood education programs have demonstrated that programs increase educational attainment, lower rates of social assistance, crime and teenage pregnancy.

Actions

Pursue a whole of government approach.

Support Aboriginal Peoples' legitimate desire to achieve self determination. In health services this means the development of Aboriginal led **regional health authorities** funded and supported by Federal and Provincial funds.

Seek commitment among Aboriginal political organizations, Provincial, Territorial and the Federal government; to a multi-year dialogue to explore common issues and agendas for action to improve Aboriginal health and well being.

Facilitate and accelerate the dissemination, transfer and translation of knowledge into potential applications and benefits through policies, interventions, services and products.

Encourage multi-lateral collaborative ventures among communities and institutions concerned with improving the health and well-being of Aboriginal peoples'. Promote multi-disciplinary, multi-institutional and multi-sectored collaborations and to build upon existing networks of policy makers and researchers to further develop capacities on Aboriginal peoples' health in areas of mutually shared priorities.

Finally, I leave the last word to the Senate Subcommittee on Population Health from its fourth report:

"The Subcommittee believes it is unacceptable for a privileged country like Canada to continue to tolerate such disparities in health"

(The Senate Subcommittee on Population Health, 2008).

THE BURDEN OF CHRONIC DISEASES AMONG ABORIGINAL PEOPLES IN CANADA

1. Introduction

According to international indicators of health, Canadians' health status is among the highest in the world. In spite of this, the well-being of Canada's Aboriginal population is comparable to that of many developing nations (Cooke, Beavon, & McHardy, 2004). This is exemplified by the increasing impact of chronic diseases on Aboriginal morbidity and mortality: while the impact of communicable diseases has declined in importance among Aboriginal populations, chronic diseases have emerged and grown into a significant health problem (Smeja & Brassard, 2000). Past and present studies have proven that Aboriginal Peoples in Canada bear a disproportionately higher burden of some chronic illnesses than do non-Aboriginal Canadians; almost one-third of Aboriginal people over the age of 15 report that they have been told by a health practitioner that they have a chronic health condition (MacMillan, MacMillan, Offord, & Dingle, 1996). For example, in 2000/01, 60.1% of the off-reserve Aboriginal population versus 49.6% of the non-Aboriginal population reported having at least one chronic condition (Tjepkema, 2002). Of particular concern are statistics that show a high prevalence of many of the core chronic diseases. The burden of disease and disease trends among Aboriginal populations will be explored for the six core chronic diseases or disease groups: (1) diabetes, (2) cardiovascular disease (CVD), (3) chronic respiratory diseases, (4) musculoskeletal conditions, (5) cancer, and (6) severe mental illness. In addition to this, the impact of chronic diseases on one's mental health, and comorbidities between the various diseases will be reviewed.

2. The Burden of Diabetes in Aboriginal Populations

2.1 Definition of Diabetes and Impaired Glucose Tolerance

Diabetes is one of the most reported and documented chronic diseases in Aboriginal health because of its recent status as an 'epidemic' among Aboriginal Canadians. The discussion of diabetes, in an Aboriginal health context, largely refers to non-insulin dependent or type 2 diabetes mellitus.

2.2 Burden of Type 2 Diabetes in Aboriginal Populations

Diabetes is considered to be a 'new' disease in the Aboriginal population that has increased rapidly in its magnitude and extent. For instance, it is only in the last 50 years that type 2 diabetes has been detected in Aboriginal populations in Canada (Health Canada, 2000; Young, Reading, Elias, & O'Neil, 2000). A steady increase in the incidence and prevalence of diabetes in Aboriginal communities has caused researchers, policy-makers, and Aboriginal communities themselves to label diabetes as an epidemic among Aboriginal Peoples (Young et al., 2000). In addition to direct concerns about the prevalence of the two diseases, its disease management and the need for adequate prevention programs, there is concern about its severe complications and relation to other chronic diseases (Young et al., 2000). Such complications affect the circulatory system, eyes, kidneys, periodontal and nervous systems, and may result in premature mortality, disability, and compromised quality of life. A study done in Manitoba projected the future

magnitude of this problem and the cause for such concern: it estimated that between 1996 and 2016, due to diabetes alone, there will be a 10-fold increase in the rate of cardiovascular disease; a 5-fold increase in strokes; 10 times as many dialysis starts; 10 times the rate of lower extremity amputations; and 5 times the rate of blindness among Aboriginal people (Greene, Blanchard, & Wajda, 1999).

2.2.1 Prevalence of Diabetes in First Nations, Métis, and Inuit Communities

As the prevalence of diabetes has been found to vary according to ancestry, language group, cultural area, and geographic location (Delisle, Rivard, & Ekoe, 1995), many of the studies conducted on diabetes in Aboriginal populations are specific to a particular community, nation, tribal council, Aboriginal population, or province. As a result, the 1991 Aboriginal Peoples Survey (APS) is the only national data available that reports on the prevalence of diabetes in First Nations, Métis, and Inuit populations (Waldram, Herring, & Young, 2006). According to the APS' self-reported diabetes data, the prevalence of diabetes is lower in Inuit populations than it is in First Nations and Métis populations (Bruce, Kliewer, Young, Mayer, & Wajda, 2003).

As the North comes into greater contact with the South and major urban centres, Inuit communities are thought to be at greater risk for contracting 'Western' diseases, such as diabetes (Bobet, 1997; Bruce, 2000, 2000; Greene et al., 1999; Hegele et al., 1999; McIntyre & Shah, 1986; Montour, Macaulay, & Adelson, 1989; Young et al., 2000). The reality of this risk has been shown in the rapidly rising rates of diabetes among Inuit Peoples in Canada (Anderson, 2004; Young, Moffatt, & O'Neil, 1993): the prevalence of diabetes among the Labrador Inuit has climbed from 1.9% of the population in 1991 to 4% in 1999 (First Nations and Inuit Regional Health Survey National Steering Committee, 1999). These recent changes support the argument that geographic isolation, later contact with European settlers, and a sustained traditional way of life, were protective factors for northern Aboriginal communities.

Although diabetes is a rising problem in the Inuit population, it has been more consistently reported as a chronic health concern for the First Nations population of Canada. However, the actual size and magnitude of the problem is still unclear. For example, the APS reported that the crude prevalence for diabetes in First Nations People was 6.4% and 8.5% for those living on- and off-reserve respectively (Bobet, 1998). In contrast, the 2002/2003 Regional Health Survey reported an age-standardized prevalence of 19.7% for First Nations People. When limited to those 55 years of age or older, the rate increased to 35% (First Nations Centre, 2005). Similarly, one in four on-reserve First Nations People over the age of 45 were reported as living with diabetes (First Nations Centre, 2004). What these later RHS numbers suggest is that the prevalence of diabetes among First Nations People may have increased since 1991. Reports from Manitoba, which are based on information gained from the provincial database on hospitalizations and physician visits, supports this hypothesis: a rising trend in diabetes prevalence can be observed since the 1990s among First Nations People (Green, Blanchard, Young, & Griffith, 2003).

While it has been documented that diabetes is a concern for all First Nations in Canada, it is important to reiterate regional and community variations. Regional or community data can provide more context-specific information and demonstrate the various dimensions of the problem. For instance, a study conducted among the Oji-Cree reported a shockingly high prevalence (40%) of type 2 diabetes and IGT; this represented the highest prevalence rate of any

subpopulation in the world and is five times that of the Canadian average (Harris et al., 1997).

Much less is known about diabetes among Métis Peoples, but rates are comparable to, or lower than, the rate in First Nations for most age-sex groups (Bruce, Kliewer, Young, Mayer, & Wajda, 2003; Health Canada, 2000). The national data, however, suggests that diabetes is generally higher among First Nations and Métis populations than the Inuit and the general Canadian population. While a smaller increase and a lower prevalence rate have been documented in the Métis population, the numbers are still higher than the national average: the crude prevalence of diabetes among Métis people was 5.5% in 1991, compared to 3.1% for the general population. According to the Métis National Council, the rate of diabetes among the Métis population as of 2006 is 5.9% (Métis National Council, 2006).

2.2.2 Gender stratification

In 1997, the rates of self-reported diabetes among First Nations men and women were reported to be, respectively, 3.6 and 5.3 times higher than among their age-sex matched non-aboriginal counterparts (First Nations Centre, 2004). While these differences demonstrate, once again, the divide between diabetes in Aboriginal and non-Aboriginal populations, they also point to the stratification of diabetes according to gender. Because this gender difference adds important information to the burden of diabetes among Aboriginal Peoples in Canada, relevant literature will be reviewed here.

In a study of two Algonquin communities in North-eastern Quebec (Delisle et al., 1995) and the Oji-Cree community of Sandy Lake in North-western Ontario (Harris, Caulfield, Sugamori, Whalen, & Henning, 1997), the prevalence of type 2 diabetes was reported to be as high as 80% among women aged 50 to 64 years. Figures reported on national data show that women represent roughly 2/3 of the First Nations people who are diagnosed with diabetes (Bobet, 1997); in the general Canadian population, the reverse is true, where diabetes prevalence is generally reported to be higher among males than females (Health Canada, 1999). In addition to experiencing an overall higher prevalence of type 2 diabetes, many Aboriginal women have been diagnosed with gestational diabetes mellitus (GDM) (Mohamed & Dooley, 1998).

GDM is defined medically as any degree of glucose intolerance experienced with the onset of pregnancy or that which is first recognized during pregnancy (Matthews, 2003). Some glucose tolerance is known to deteriorate in all pregnant women as a result of the physiological and hormonal changes that accompany pregnancy (Hod, 2003). And, in the Western world, the deterioration of glucose tolerance reaches a sufficient level to fulfill the diagnostic criteria for gestational diabetes in approximately 2-3% of pregnancies (Whitaker, Pepe, Seidel, Wright, & Knopp, 1998). Surveys in northern Quebec and Ontario have suggested that gestational diabetes may affect as many as 13% of pregnancies among Aboriginal women (Godwin, Muirhead, Huynh, Helt, & Grimmer, 1999; Harris et al., 1997; Rodrigues, Robinson, & Gray-Donald, 1999). It has been suggested that difficulties with the documentation of the prevalence rates for gestational diabetes might be contributing to the high rates of GDM observed in many Aboriginal communities: for example, the first-time diagnosis of type 2 diabetes during pregnancy, and not etiologic GDM, is counted within the numbers. However, some research has shown that just under half of all pregnancies in women 35 years and older are associated with either pre-existing type 2 diabetes or gestational diabetes (Harris et al., 1997). This information raises serious concerns about diabetes among Aboriginal women.

The prevalence rates, risk factors and outcomes of GDM between Aboriginal and non-Aboriginal women were directly compared for the first time in a Saskatchewan study (Dyck, Klomp, Tan, Turnell, & Boctor, 2002). This study reported that among residents within the Saskatoon District Health (SDH) region, the one-year prevalence rates for GDM were 3.7% for non-Aboriginal women and 6.4% for Aboriginal women. For residents outside SDH, GDM prevalence rates were 3.1% for non-Aboriginal women and 22.8% for Aboriginal women (Dyck et al., 2002). The greatest concern with GDM and maternal experiences of, or risks for, diabetes is the persistence of the disease beyond the woman's gestational period. For instance, a study in the Sioux Lookout Zone, reported that 70% of women diagnosed with GDM developed overt diabetes within 3 years (Mohamed & Dooley, 1998). This suggests a pressing need to target women's health and diabetes in Aboriginal communities.

2.2.3 The Childhood Burden of Diabetes

An increased prevalence of diabetes among a higher proportion of the younger Aboriginal population and an exaggerated prevalence of the early onset of diabetes in Aboriginal populations is a concern for Aboriginal children and youth. For example, a study documenting diabetes rates among the Haida Gwaii in British Columbia noted that 17% of adults age 35+ have type 2 diabetes (Grams et al., 1996). Comparisons between First Nations communities and the general population show that more than half (53%) of First Nations people living in First Nations communities with diabetes are 40 years or younger and 65% are less than 45 years (First Nations and Inuit Regional Health Survey National Steering Committee, 1999). As evident in the traditional label of adult onset diabetes, type 2 diabetes has typically not been observed in youth (Health Canada, 2000). New cases in First Nations children, such as those detected among children as young as 5 to 8 years of age in the Island Lake region of north-eastern Manitoba (Dean, Mundy, & Moffatt, 1992) and in northern Ontario (Harris, Perkins, & Whalen-Brough, 1996) put this label into question. In addition, screening for diabetes in a remote northern Ojibwa-Cree community using fasting plasma glucose levels, found a high prevalence rate (3.6%) among females aged 10 to 19 years (Dean, 1998; Dean, Young, Flett, & Wood-Steiman, 1998).

In general, Aboriginals are younger than the general population at the time of diagnosis and the onset of complications, and suffer greater disease severity at diagnosis (Goulet et al., 2006; Health Canada, 2000; Ho, Gittelsohn, Harris, & Ford, 2006; Meatherall et al., 2005; Pohar & Johnson, 2007; Simpson, Corabian, Jacobs, & Johnson, 2003). Despite their younger age Aboriginal people also suffer from higher mortality rates, higher complication rates, higher hospitalization rates, and longer hospital stays (Goulet et al., 2006; Health Canada, 2000; Pohar & Johnson, 2007; Simpson et al., 2003). This causes grave concern for the health and well-being of future generations.

2.3 Understanding the Numbers Now and in the Future

The statistics available on diabetes among Aboriginal Peoples in Canada tell us that the distribution of diabetes among Canadian Aboriginals varies markedly according to gender, geographical area, language group, culture area, latitude, longitude, and degree of isolation (Boston et al., 1997; Health Canada, 2000; Jin, Martin, & Sarin, 2002; Macaulay et al., 2003; Travers, 1995; Young, Reading, Elias, & O'Neil, 2000; Young, Szathmary, Evers, & Wheatley,

1990). In general, the prevalence is higher in the south than in the north, higher among women than men, higher among the less educated, and higher among urban and acculturated Aboriginals (Bruce et al., 2003; Daniel, Gamble, Henderson, & Burgess, 1995; Health Canada, 2005; Jin, Martin, & Sarin, 2002; Travers, 1995; Young et al., 1990; Zimmet, Dowse, Finch, Serjeantson, & King, 1990). Despite what can be learnt from these numbers, a reliance on the number of reported diabetes diagnoses to determine prevalence rates can be questioned in terms of its reliability: because the onset of diabetes occurs an average 4-7 years before diagnosis, those currently diagnosed do not represent the total burden of disease (First Nations Centre, 2005; McKinlay & Marceau, 2000; Young et al., 2000). For example, in Manitoba, undiagnosed diabetes constitutes approximately one-third of all cases of diabetes (Bruce et al., 2003), and across Canada, the actual number of diabetics is probably 2 to 3 times greater (Health Canada, 2000).

Further, because diabetes is developing earlier and at higher rates in the Aboriginal population, the impact of this disease on the health of the next generations is worrisome. It has been postulated, for example, that if these trends remain unchanged that the number of Aboriginal people with diabetes in Canada will triple by the year 2016 (Jin et al., 2002).

3. The Burden of Cardiovascular Disease in Aboriginal Populations

3.1 Definition and Description of Cardiovascular Disease

Cardiovascular disease (CVD) has been noted to have the largest economic burden of any illness on Canada's health care (Health Canada, 2003, 2005; Lidgren, 2003). Since the 1960s, CVD has been decreasing in North America (Dorner & Rieder, 2004): much of the reduction in incidence and mortality has been attributed to lifestyle changes and behaviour modification, such as improving one's diet, exercising more frequently, and quitting smoking (Sytkowski, D'Agostino, Belanger, & Kannel, 1996). Despite such changes, CVD remains the leading cause of death in most Western countries (Dorner & Rieder, 2004). The economic, social, and personal health burdens related to CVD in Canada, therefore, make it an important chronic disease to discuss and examine with regards to its impact on Canada's Aboriginal population.

In an attempt to combat the current Canadian health crisis, a steering committee was created to develop the Canadian Heart Health Strategy and Action Plan (CHHS-AP) to set ambitious health targets for 2020 and produce recommendations for reaching those targets. One such target is to "end the CV[D] health crisis among Aboriginal/Indigenous peoples" by reducing the health burden of CVD on the Aboriginal population to parity with all other Canadians. Recommendations for achieving this target include: taking a partnership approach involving Aboriginal communities and government; creating a national Aboriginal Centre for chronic disease prevention and management; and helping Aboriginal peoples lead healthier lives through culturally appropriate means (Committee, 2009).

One must be careful when discussing CVD, as it is not just one disease. In fact, CVD refers to a heterogeneous class of diseases that concern the heart and/or circulatory system (Waldrum et al., 2006). The most common type of CVD is coronary heart disease (CHD), also referred to as ischemic heart disease (IHD), or coronary artery disease (CAD). IHD is a condition in which fatty deposits accumulate in the cells lining the walls of the coronary arteries, which serve as the

heart's main blood supply. When fatty deposits gradually build up in the coronary arteries, the arteries become hard and narrow from atherosclerosis. Ischemia, which is a decreased supply of oxygenated blood to the heart muscle, develops from these conditions and can cause permanent damage to the heart. Complete blockage of the coronary arteries will lead to a heart attack (myocardial infarction) (Ontario Program for Optimal, 2001). While populations undergoing the transition from high to low rates of infectious diseases, such as Aboriginal Canadians, tend to experience decreasing rates of diseases such as rheumatic heart disease, which is caused by infection, they also tend to experience increasing rates of IHD, which results from lifestyle and socioeconomic changes (WalDRAM et al., 2006). Despite the interest in IHD, its causes, and its risk factors, data are often only available on CVD as a whole (WalDRAM et al., 2006). As such, this section will discuss the general prevalence of CVD and, wherever possible, refer to ischemic heart disease (IHD).

3.2 Burden of Cardiovascular Disease in Aboriginal Populations

While there has been a documented decline in IHD prevalence across the Western world (Dorner & Rieder, 2004), such a decline has not been observed in certain subgroups of the population, such as Canada's Aboriginal Peoples. Traditionally, Aboriginal Peoples have experienced a low prevalence of IHD when compared to their non-Aboriginal counterparts (Anand et al., 2001). However, recent political, social and economic changes experienced by many Aboriginal communities have resulted in significant nutritional and lifestyle changes, such as a more calorie-dense and sedentary lifestyle, (Anand et al., 2001) that have contributed to an increase in IHD prevalence (Anand et al., 2001; Shah, Hux, & Zinman, 2000; Yusuf, Reddy, Ounpuu, & Anand, 2001).

Higher rates of IHD in Aboriginal populations was first documented in national studies of mortality among First Nations communities in the 1970s and 1980s (WalDRAM et al., 2006). These studies found, however, that the rate of IHD was higher in females, but not in males (Mao, Moloughney, Semenciw, & Morrison, 1992; Mao, Morrison, Semenciw, & Wigle, 1986). In 1999-2000, the age-standardized mortality rate (ASMR) for all cardiovascular diseases was found to be slightly higher, but not a statistically significant difference, among First Nations people than it was among Canada's general population (Health Canada, 2003; WalDRAM et al., 2006). An increase in IHD prevalence among Aboriginal Peoples in Canada, however, was definitely documented in a study conducted among forty-one First Nations communities in Ontario (Shah et al., 2000). This study demonstrated that provincial hospital admission rates for IHD had more than doubled among the forty-one First Nations communities – from 76 per 10,000 persons in 1984 to 186 per 10,000 in 1995 – while declining for the rest of the province (Harris et al., 2002; Shah et al., 2000). Among Sandy Lake residents, admission to hospital for IHD increased from a rate of 34.8 per 10,000 to 109.1 per 10,000 in 15 years (Harris et al., 2002). A parallel trend was found in the admission rates for acute myocardial infarction (AMI or heart attacks) (Shah et al., 2000). Further, AMI rates among First Nations are about 20% higher than the Canadian rate (First Nations and Inuit Health Branch, 2000/2001).

Data from 1981 to 1997 demonstrated that hospitalizations for illnesses relating to circulatory disease more than doubled for First Nations population in Ontario during this time period (Shah, Hux, & Zinman, 2000), suggesting that circulatory disease has been increasing in importance as a major cause of morbidity. This hypothesis was corroborated when results from the 1997 RHS

found that heart disease is 3 times higher and hypertension 2.5 times higher among First Nations/Inuit than among the general Canadian population (First Nations Centre, 2004). Further still, statistics from the 2002/03 RHS, which documented self-reported heart conditions in First Nations communities, reported a prevalence slightly higher than that of the Canadian population (7.6% vs. 5.6%) (First Nations Centre, 2005). When controlled for specific age groups, First Nations adults were well above the Canadian average: First Nations adults 50 to 59 years of age had a prevalence of self-reported heart disease of 11.5% compared to 5.5% for the general Canadian population (First Nations Centre, 2005). While these statistics show that IHD poses an increasing threat for First Nations communities in Canada, the prevalence of CVD and specifically IHD in other Aboriginal communities is limited (Métis) and inconclusive (Inuit).

The challenge with understanding IHD in Arctic Native groups is that reports are conflicting. It has long been recognized and reported that IHD rates are lower than those of the general population (Bjerregaard & Dyerberg, 1988; Middaugh, 1990; Waldram et al., 2006; Young et al., 1993). The reasoning for these low rates compared to First Nations is often attributed to the typically remote location of Aboriginal communities: their traditional marine diet and way of life are often thought to have acted as protective factors (Dewailly et al., 2001). The reliability of the mortality statistics and other data used for these studies, however, has been questioned (Bjerregaard, Young, & Hegele, 2003). It is more accurate to say, therefore, that evidence documenting rates of CVD in Northern and Inuit communities is inconclusive. Bjerregaard, Young, and Hegele (2003) go on to say that there is a need to reassess the data on CVD in Inuit populations and re-evaluate the potential protective factors that a traditional diet can provide against rapid westernization and its related health risks.

As the concerns with Inuit CVD statistics demonstrate, and as is the case with all Aboriginal health issues, there are important regional and intertribal differences in CVD risk factors and disease rates. While the Inuit and Métis populations are important populations to target for future research, so too is the urban Aboriginal community (Yusuf, Reddy, Ounpuu, & Anand, 2001). This is because most of the current data on CVD come from Aboriginals living on reserves and, therefore, very little is known about the burden of disease among the off-reserve population (Yusuf et al., 2001). Therefore, studies that target all subsets of the Aboriginal population in Canada will be necessary to better understand the burden of cardiovascular disease among the Aboriginal population in Canada.

4. The Burden of Chronic Respiratory Diseases in Aboriginal Populations

4.1 Definition and Description of Chronic Respiratory Diseases

For this review, “chronic respiratory diseases” refers to any recurrent or persistent respiratory ailment related to the upper and/or lower respiratory system (i.e. the airways and other structures of the lung). Commonly cited chronic respiratory diseases are: asthma, chronic obstructive pulmonary disease (COPD), respiratory allergies, occupational lung diseases, chronic respiratory tract infections, tuberculosis, and pulmonary hypertension (World Health Organization, 2008).

In order to engage in a productive discussion of chronic respiratory tract infections in Canada’s Aboriginal population, this section will focus on five key conditions discussed in the literature, which pose a significant current or potential impact on the health and well-being of Aboriginal

Peoples in Canada. They are: (1) tuberculosis, (2) chronic otitis media, (3) chronic/recurrent respiratory tract infections, (4) chronic obstructive pulmonary disorder (COPD) and (5) asthma. First, however, a brief overview of chronic respiratory disease in Aboriginal populations is provided below.

4.2 General Burden of Chronic Respiratory Disease in Aboriginal populations

Although chronic respiratory conditions are traditionally uncommon in First Nations communities (Sin, Wells, Svenson, & Man, 2002), Canada's Aboriginal population is adversely (and increasingly) affected by respiratory disease when compared with their non-Aboriginal counterparts (Mao et al., 1984; Mao et al., 1992; Mao et al., 1986; Morrison, Semenciw, Mao, & Wigle, 1986; Young, 1983). For instance, Canada's Aboriginal population is at an increased risk of death from respiratory diseases and experience an excess of morbidity (Fraser-Lee & Hessel, 1994). The risks for and burden of respiratory disease is especially profound for Aboriginal children: 13 out of 20 respondents in a survey of native children's health ranked respiratory illness as the most serious child health concern (Petersen, Singleton, & Leonard, 2003). A prospective study of children born in 1973 in Canada's north reported that respiratory illness accounted for 36% of infant deaths and was the leading cause of infant mortality (Orr, McDonald, Milley, & Brown, 2001). This statistic is compounded by the fact that infant mortality rate among Aboriginal Peoples is double the Canadian average (Sin et al., 2002).

4.3 Tuberculosis

Tuberculosis (TB) is a chronic bacterial infection that is spread through the air and usually infects the lungs (U.S. National Library of Medicine and the National Institutes of Health, 2005). Tuberculosis is classified as a chronic disease because individuals with TB remain infected for life. Since the development of treatment (antibiotics) and prevention (vaccines) for this disease, TB is largely thought to be a concern of the past. Unfortunately, this is far from the truth: about 2 million people die from this treatable (Health Canada, 2002) disease each year (Skeiky & Sadoff, 2006; World Health Organization, 2005). Not surprisingly, TB infection and mortality is most common in developing nations, where poverty, poor (or no) access to health care, and inadequate living conditions persist (World Health Organization, 2005). For similar reasons, Canada's Aboriginal population is still fighting this disease (Public Health Agency of Canada, 2002). As TB is the leading cause of death in HIV/AIDS-infected individuals (Grange, Story, & Zumla, 2001; Skeiky & Sadoff, 2006) and HIV/AIDS is a serious and increasing concern within Canada's Aboriginal population (First Nations and Inuit Regional Health Survey National Steering Committee, 1999; Ring & Brown, 2002; Spittal et al., 2002), the interactions between HIV/AIDS and TB, as well as their independent health risks, should continue to be of focus and interest for future research (Health Canada, 2002).

4.3.1 Adult Burden of Disease

Tuberculosis among Aboriginal Canadians reached epidemic proportions following their contact with European settlers, which began in the 16th century and carried on until the 20th century (Hoepfner & Marciniuk, 2000). The Public Health Agency of Canada (PHAC) has reported that TB incidence continues to follow patterns of colonization, which run on a gradient from south to north: tuberculosis rates are highest in the prairie provinces and the north, where contact with Europeans occurred after Aboriginal communities located in more southern regions (Public

Health Agency of Canada, 2002). Since the Aboriginal population was infected with TB later than the non-Aboriginal population of Canada, it is not entirely surprising that Aboriginal people continue to suffer a higher burden of this disease (Gaudette & Ellis, 1993; Wang, Noertjojo, Elwood, & FitzGerald, 2000). What is surprising is the increased disparity between the prevalence of TB in Aboriginal and non-Aboriginal populations.

Since the beginning of the 20th century, tuberculosis rates have fallen dramatically in Canada, and they continue to decrease today (Public Health Agency of Canada, 2002; Wang et al., 2000). However, rates of TB infection within Canada's Aboriginal population have not seen as significant a decline (Wang et al., 2000) and are now considerably higher than the Canadian average (Young & Casson, 1988). In 1970, the Aboriginal rate was twelve times higher than the non-Aboriginal rate, with 212 cases per 100,000 population compared with 17; by 1995, the Aboriginal rate was thirty-nine times higher, with 70 per 100,000 population cases versus 1.8 (Hoeppner & Marciniuk, 2000). In order to get a more accurate reading of the prevalence of TB in Aboriginal populations, data obtained by Health Canada between 1990 and 2000 was controlled for ethnicity. With such a control, it was demonstrated that Aboriginal incidence rates rise from 8-10 times to 20-30 times the Canadian-born, non-Aboriginal average (Health Canada, 2002).

These and other statistics documenting the high burden of disease in the Aboriginal population in Canada indicates that tuberculosis will be an ongoing concern for the future (Smeja & Brassard, 2000). In 1999, 16% of new active and relapsed TB cases that were reported to the Canadian Tuberculosis Reporting System (CTBRS) were from the Aboriginal population (Public Health Agency of Canada, 2002). This number is disproportionately high considering that Aboriginal people only make up 4.4% of the Canadian population (Statistics Canada., 2003). The fact that 92% of the Aboriginal cases were new active cases causes even more concern for the persistence and presence of the disease (Health Canada, 2002). The significantly younger age of Aboriginal people with TB, as compared with their non-Aboriginal counterparts, is also concerning for the future. The burden of TB experienced by Aboriginal children and youth is further discussed below.

4.3.2 Child and Youth Burden of Disease

In 2002, Health Canada reported that young Aboriginal adults (15-34 years of age) have the highest proportion of infectious tuberculosis cases and are at the greatest risk of contracting the disease (Health Canada, 2002). In addition to high youth rates, paediatric cases of TB in 1999 were observed to be 29 times higher in Aboriginal populations than in the general population (Health Canada, 2002). Although this reflects a decreased rate of infection from previous years (Health Canada, 2002), the critical numbers emphasize the magnitude of its impact on the younger generations.

A brief plateau in the rate of TB infection occurred during the 1980s; this was an anomaly to a decreasing trend occurring in the 20th century. In response to the sustained prevalence of TB in Canada in the 1980s, newborns were routinely vaccinated with bacilli Calmette-Guerin (BCG). Since this time, the BCG has become the world's most widely used vaccine, despite evidence of variable efficacy (0-80%) (Andersen & Doherty, 2005). Data from animal and human trials indicate that variances are related to pre-existing immune responses to antigens that are common to environmental mycobacterium and mycobacterium TB (Andersen & Doherty, 2005). In Cree

communities, BCG has been administered since 1982¹ (Smeja & Brassard, 2000). The efficacy of BCG in preventing pulmonary TB is still unknown, but meta-analyses suggest that its efficacy in preventing serious forms of TB in children can be up to 80% successful (Colditz et al., 1995). The absence of active TB and TB meningitis diagnoses among Cree infants since 1980 also provides some evidence for the protective effects of the BCG vaccination (Smeja & Brassard, 2000). However, Current thinking on the BCG vaccine is that it should only be administered to newborns with the highest risk, which includes many Aboriginal infants and those with HIV positive mothers (Colditz et al., 1995; Menzies, Tannenbaum, & FitzGerald, 1999).

4.4 Chronic Otitis Media

Otitis media is an inflammation or infection of the middle ear, which occurs when the Eustachian tube (the passage from the throat to the middle ear) is blocked (U.S. National Library of Medicine and the National Institutes of Health, 2005). This condition can be chronic or acute, suppurative or secretory (Med-Help, 2005). This review will focus on chronic otitis media, as its purpose is to study chronic respiratory problems in Canada's Aboriginal population. Since chronic suppurative otitis media (CSOM) is the most common form of infection, this is what chronic otitis media refers to in the rest of the document. While otitis media is not usually included in discussions of chronic respiratory diseases, it is related to the under-recognized area of chronic bacterial respiratory infections (Morris, 1998). It is specifically included here because of its prevalence in the Aboriginal population and because it is important to study it in the context of its respiratory etiology.

Chronic otitis media occurs when the Eustachian tube is repeatedly blocked or remains blocked for long periods of time; this may be the result of a lingering acute ear infection or persistent ear infections (U.S. National Library of Medicine and the National Institutes of Health, 2005). Prolonged or repeated infections can permanently damage the ear and cause partial or complete deafness (Med-Help, 2005; U.S. National Library of Medicine and the National Institutes of Health, 2005). Since ear infections are most common in children, chronic otitis media usually develops at a young age and persists into adulthood (Med-Help, 2005), causing considerable damage to the ear throughout the life cycle.

Chronic suppurative otitis media (CSOM) is uncommon in most developed countries, which is why it is often described as a disease of poverty (Coates, Morris, Leach, & Couzos, 2002). The World Health Organization (WHO) has defined a prevalence of 4% or greater for CSOM as a "massive public health problem" (World Health Organization, 1998). In many Aboriginal communities and populations in circumpolar regions (Martin & Macdonald, 1998), the proportion of children with CSOM is ten times the WHO's cut-off (Coates et al., 2002). In response to a high prevalence of otitis media among Aboriginal Peoples in North America in the 1960s, a mandatory notification program for severe cases of otitis media was introduced (Morris, 1998). A program to ensure continued surveillance of the disease is needed today (Morris, 1998) since otitis media is endemic among Canada's northern Inuit, First Nations, and Métis children: prevalence rates for these communities are sometimes reported to be as much as 40 times those found in non-Aboriginal urban communities (Bowd, 2005).

¹ From 1982 to 1989, BCG was repeated at age one if the child's annual tuberculin skin test (TST) was less than 5 mm; since 1989, BCG has only been given to children at birth.

Much of the research on otitis media in Aboriginal populations has been done in Australia. Although there are obvious geographic and cultural differences between Canada's and Australia's Indigenous populations, strong parallels can be drawn between their health status: Canadian Aboriginals bear a disproportionate burden of this disease comparable to their Australian counterparts (Coates et al., 2002), which is why trends from Australia have relevance for Indigenous peoples in Canada. In order to exemplify the prevalence of this disease in Aboriginal communities, a review of some important Australian studies is provided below. In the future, similar studies should be done in Canada in order to develop accurate and useful Aboriginal statistics.

In Australia, severe otitis media in rural Aboriginal children is part of the spectrum of chronic bacterial infections of the respiratory tract that burdens this population (Leach, 1999; Leach & Morris, 2001; Morris, 1998). The high rates of CSOM demonstrate the absolute burden on Australian Aboriginal health: 95% of Aboriginal children observed had otitis media, versus 30% of non-Aboriginal children (Boswell & Nienhuys, 1996).

The situation is even worse in rural and remote regions, where this chronic disease affects almost every child (Leach, 1999). In one rural Aboriginal community, all infants under three months of age were diagnosed with acute otitis media; a follow-up study indicated that the situation had not resolved itself by early childhood, as 60% of the cases developed into chronic otitis media (Leach, 1999). The long term impacts of this disease is further exemplified by a study in the Northern Rivers Area (a region in New South Wales, Australia), where among 61.08% of the children studied had middle ear problems of some type, 10.8% had unilateral hearing loss and 22.16% had bilateral hearing loss (Thorne, 2003). Since extremely high resultant rates of conductive hearing loss (>50%) were often attributed to this population's poor classroom success (Leach, 1999), this disease presents considerable physiological and sociological problems and challenges for the community.

Furthermore, Australia's National Trachoma and Eye Health Program (NTEHP) highlighted the prevalence co-morbidity of this disease among its Aboriginal population (Moran, Waterford, Hollows, & Jones, 1979): otitis media was the most common bacterial respiratory disease diagnosed by health officials and was associated with extremely high rates of pneumonia, meningitis, and bronchiectasis in the Aboriginal population (Gandevia, 1967; Hanna & Torzillo, 1991; Maxwell, 1972; Torzillo et al., 1995; Torzillo, Waterford, Hollows, & Jones, 1983). A similar association was documented for Indigenous people in Papua New Guinea, where early infections in the nasopharynx and high rates of pneumonia were linked to a high prevalence of otitis media (Gratten et al., 1986; Montgomery et al., 1990).

Despite the lessons that can be learned from Australia's research in this area, it is important to consider the particularities of the burden of chronic otitis media among Canada's Aboriginal population. This means developing targeted, focussed studies to assess the incidence, prevalence, and overall burden of the disease.

4.5 Chronic/Recurring Respiratory Tract Infections

An acute respiratory tract infection (Jacono, Jacono, Cano, Segami, & Rubin, 1996) can affect one or both of the upper and lower respiratory systems and can be a short-lived, persistent, or

recurrent condition. The most common respiratory tract infections are bronchitis, bronchiolitis, pneumonia, pneumonitis, and croup (Kurzius-Spencer, Wind, Van Sickle, Martinez, & Wright, 2005).

For reasons largely unknown, Aboriginal children tend to have an increased risk of developing respiratory tract infections (Evers, Orchard, & McCracken, 1985; Harris, Glazier, Eng, & McMurray, 1998; Orr et al., 2001; Sin et al., 2002): over 90% of native children studied experienced a lower respiratory infection² within their first year of life (Petersen et al., 2003). Although no comparison to a Caucasian population was given in this study (Petersen et al., 2003), other studies demonstrate that Aboriginal children have greater respiratory concerns than their non-Aboriginal counterparts. For example, Evers et al. (Evers et al., 1985; Evers & Rand, 1982, 1983), who extensively examined the impact of acute respiratory infections (ARI) on Aboriginal and non-Aboriginal populations in South-western Ontario, found that despite the affluence of the Aboriginal communities studied³, the incidence of lower respiratory disease among First Nations children was almost three times that of the non-Aboriginal population (Evers et al., 1985). A population-based study of infants and young children in North-western Ontario documented similar findings: respiratory tract infections were reported to be the main cause of illness in this population, and Aboriginals were more likely to report respiratory conditions than the non-Aboriginal children studied (Harris et al., 1998). More specifically, the incidence of pneumonia has been reported to be 17 to 18 times greater for native children under the age of two than for non-native children (Evers & Rand, 1982, 1983). As Inuit populations in Canada demonstrate similar trends for lower respiratory problems, it is reasonable to assume that all of Canada's Aboriginal peoples experience a high risk of upper and lower respiratory tract infections (Fraser-Lee & Hessel, 1994; Koch et al., 2003).

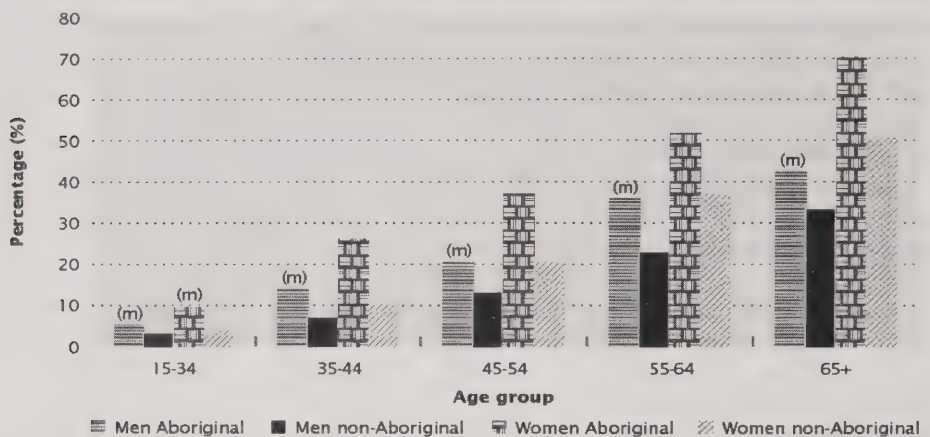
The prevalence of ARIs in Aboriginal children is worrisome because these infections have the potential to develop into chronic conditions: respiratory infections weaken the pulmonary system, which can cause permanent lung damage and lead to the development of chronic conditions (Anto, Vermeire, Vestbo, & Sunyer, 2001). The risk of Aboriginal Peoples developing chronic respiratory conditions from ARIs is evidenced by the tendency for Status Indian children to have multiple episodes of pneumonia and bronchitis (Fraser-Lee & Hessel, 1994). Within the first two years of life, Aboriginal children experience repetitive bouts of pneumonias, bronchiolitis, and are routinely hospitalized for respiratory complications (Petersen et al., 2003). Although these often improve after the age of two, recurrent wheezing and chronic coughing has been shown to continue throughout life (Petersen et al., 2003). Evidence for a link between infections and chronic disease was reported in a recent study of Alaskan natives, when 40% of the children studied showed signs of respiratory infections and chronic respiratory disease (Lewis et al., 2004). A study of young Indigenous children in New Guinea made similar observations: a significant relationship was found between the presence of early respiratory infections and the subsequent onset of asthma (Anderson, 1978).

² "Lower respiratory tract infection" refers to bronchitis, bronchiolitis, or pneumonia.

³ The communities studied were reported as having much higher living standards and greater access to medical care than other aboriginal regions in Canada.

4.6 Chronic Obstructive Pulmonary Disease (COPD) and Asthma

Chronic obstructive pulmonary disease (COPD) is identified by a patient's "shortness of breath, cough, and sputum production" (Cardinal, 2004); its long-lasting course is characterized by an irreversible decline of forced expiratory volume in one second (FEV1), increasing presence of dyspnoea and other respiratory symptoms, and a progressive deterioration of health status (Cardinal, 2004). COPD's broad impact on the respiratory system means that it often overlaps with other respiratory conditions, such as chronic bronchitis, emphysema, and asthma that share common symptoms and have co-morbid interactions (Anto et al., 2001). Nonetheless, this respiratory problem, alone, has been noted as a leading cause of mortality and disability world-wide: approximately 5-15% of adults in industrialized countries have COPD (Anto et al., 2001), and the numbers continue to grow. In 1990, COPD was the twelfth known cause of combined mortality and disability world-wide: by 2020, it is expected to rank fifth (Anto et al., 2001). As such, this disease will require comprehensive hospital and community health services in Canada.



Note: Differences between Aboriginals living off-reserve and non-Aboriginals are statistically significant at $p < 0.05$ for females of all age groups and for males aged 35 to 44.

(m) indicates that the coefficient of variation is between 16.6% and 33.3%.

Asthma shares many similar symptoms, risk factors, and treatment methods with COPD (Anto et al., 2001), which is why they are often grouped together. However, it is important to identify them as separate chronic diseases. By definition, "asthma is a chronic health disorder characterized by symptoms of cough, shortness of breath, chest tightness, and wheeze" (Cardinal, 2004). Asthma is the most common chronic disease afflicting children today (Lewis et al., 2004), and the prospects of this disease are not promising: childhood asthma is increasing in prevalence and severity, especially among children 5 years of age and younger (Woolcock & Peat, 1997). Historically, asthma has not affected Aboriginal Peoples, but its increasing prevalence in Aboriginal populations today demonstrates that these communities are becoming very vulnerable to the disease (Downs, Marks, Belosouva, & Peat, 2001; Liu et al., 2000; Sin et al., 2002).

The prevalence of asthma in Canada's Aboriginal population has been progressively explored since Houston et al. (Houston, Weiler, & MacKay, 1979) reported a high prevalence of chronic

cough and bronchial wall thickening among native children, as compared to white children, in northern Saskatchewan (Kurzius-Spencer et al., 2005). Recent studies of American and Canadian Aboriginals have shown that Aboriginal people are considerably burdened by asthma (Lewis et al., 2004; Liu et al., 2000; Sin et al., 2002): Aboriginal children in their first year of life have rates of hospitalization for asthma and bronchiolitis that are two to three times the rate of non-Aboriginal children (Lewis et al., 2004; Liu et al., 2000). In connection with asthma, native children have also reported higher hospitalization rates than non-native children for wheezing and breathing problems (Liu et al., 2000; Sin et al., 2002).

Within Canada, Aboriginal-specific research will be needed to create new policies and programs aimed at reducing the burden of COPD and asthma, since studies on Aboriginal peoples report that this population is 2.1 times (95% CI 2.0, 2.2) and 1.6 times (95% CI: 1.6, 1.6) more likely to have an emergency hospital appointment and office visit for asthma or COPD, respectively, as compared with their age-matched, sex-matched non-Aboriginal counterparts (Sin et al., 2002). The fact that Aboriginal people were also 55% (95% CI: 52, 58) less likely to see a specialist and 66% (95% CI: 63, 70) less likely to undergo spirometry for these conditions than non-Aboriginal people (Sin et al., 2002) raises significant concern about the adequacy of health services and health policies in Canada.

5. The Burden of Musculoskeletal Conditions in Aboriginal Populations

5.1 Definition and Description of Musculoskeletal Disease and Disorders

Musculoskeletal diseases and disorders have been identified as the most common cause of severe pain and disability (Lidgren, 2003). As a result, they place a massive burden on societies and health care systems around the world (Lidgren, 2003). In Canada, musculoskeletal diseases and disorders account for 10.3% of the total economic burden of illness: second only to cardiovascular diseases (Canada, 2003, 2005; Lidgren, 2003). The economic burden of these diseases is only expected to increase as the Canadian population increases (Lidgren, 2003). As such, musculoskeletal conditions are a timely and relevant topic to discuss. The incidence and prevalence of these diseases in Aboriginal populations is important to consider, as the Aboriginal population also ages and as chronic diseases become a more prominent feature of Aboriginal health.

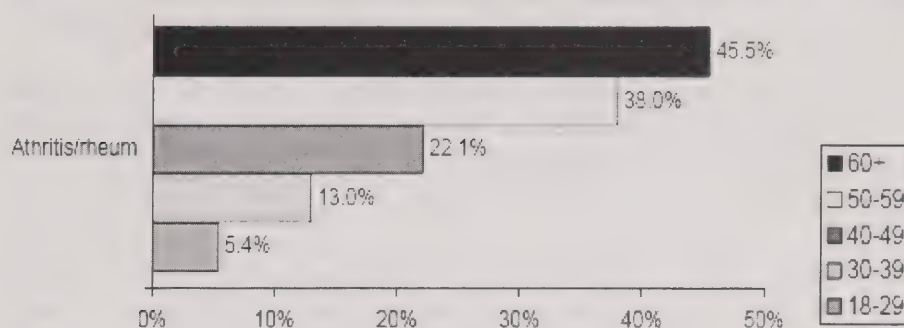
In order to begin to examine and discuss the burden of musculoskeletal diseases and disorders in Aboriginal populations, it is important to be clear as to what this title encompasses. Classification of musculoskeletal diseases and disorders has changed over time, making it difficult to determine the availability and reliability of information and certain diseases and disorders (Jacobson, 1994). For example, according to a 1989 WHO report, there were over 100 diseases and disorders of the musculoskeletal system, which were referred to as 'rheumatic diseases' and characterized by inflammation of the connective tissues, especially the muscles, joints, and associated structures (Britannica., 2006; WHO, 1989). However, the modern disease classification (ICD-10) does not include such term as 'rheumatic diseases;' instead, musculoskeletal diseases and disorders are classified according to the affected organ (ICD-10, 2006). Alternatively, some researchers use the 1958 ACR (formerly, the American Rheumatism Association) criteria in their studies, while others used 1987 ACR criteria. While still debated it seems that the term "musculoskeletal diseases and disorders" includes nearly 150 different

diseases and disorders (Lidgren, 2003).

Out of these many diseases and disorders, arthritis is the most common and most prevalent. At its most basic level, arthritis means inflammation of the joints: ‘arth’ meaning joint, ‘itis’ meaning inflammation (Canadian Arthritis Society, 2004). It would be overly simplistic, however, to assume that arthritis is one condition when, in fact, there are a number of different types of arthritis (Canadian Arthritis Society, 2004). Two of the most common arthritic conditions are rheumatoid arthritis and osteoarthritis (Canada, 2003; Canadian Arthritis Society, 2004). Other common types of arthritis discussed in the literature include: spondyloarthropathies and arthropathies associated with systemic lupus erythematosus and gout (Canada, 2003). While there are many different types of arthritis, much of the literature reports on the prevalence of musculoskeletal conditions using the general heading “arthritis/rheumatism:” this label is used to refer to the collection of painful joint disorders that range from those related to wear and tear of cartilage (i.e. osteoarthritis) to those associated with inflammation resulting from an immune disorder (i.e. rheumatoid arthritis). Because of this often dual reference, it is often difficult to separate these two conditions. As such, an examination of the burden of arthritis is based on general information about chronic arthritic conditions (including rheumatoid arthritis). The specific burden of rheumatoid arthritis, however, will not be discussed separate from the general discussion of arthritis, as its etiology is largely unknown and because it is likely a result of infection is largely considered to be preventable and not predisposed to risk factors across the life course. More general understandings of arthritis as a preventable condition make this general term more appropriate to discuss, as is the specific burden of osteoarthritis. In addition to the general burden of arthritis and osteoarthritis, osteoporosis will be discussed. Osteoporosis is often discussed in tandem with arthritis because it is also a condition of the bones. Rather than the characteristic inflammation and joint damage of arthritis, osteoporosis is characterized by very low bone mass that leads to an increased risk of atraumatic or low impact fractures (Dictionary, 2002; ICD-10, 2006).

5.2 Burden of Arthritis in Aboriginal Populations

In the general Canadian population, arthritis is one of the most prevalent chronic conditions in Canada and the number one cause of disability and health care utilization (British Columbia, 2001; Canada, 2003; WHO, 1989). Arthritis has also been cited as the most common chronic condition in Canada’s Aboriginal population (British Columbia, 2001; Canada, 2003; Canadian Arthritis Society, 2004; John, 2000; RHS, 2002/2003). For example, a study conducted in British Columbia found that arthritis was more common among Aboriginal people (17%) than in the general population (5%) (Canada, 2001). Likewise, prevalence of self-reported arthritis is also higher in the American Indian, Eskimo and Aleut populations (17.5%), compared with US White population (15.2 %) (Lawrence, Deyo, & Hochberg, 1998). In Manitoba, it was found that twice as many First Nations Manitobans were diagnosed by a physician for rheumatoid arthritis, degenerative arthritis and other non-descript forms of arthritis, compared to non-Aboriginal Manitobans (Barnabe, Elias, Bartlett, Roos, & Peschken, 2008). As arthritis involves damage to the joints of the body, it is not surprising that this condition tends to increase with age. The significant increase in the distribution of arthritis among First Nations adults according to age is exemplified in the figure below (First Nations Centre, 2005).

Figure 1. Prevalence of arthritis among First Nations adults by age group (total age adjusted)

Source: (First Nations Centre, 2005).

Arthritis has also been documented to vary across gender lines, with women being disproportionately represented. Arthritis is particularly high among older Aboriginal women: 70% of Aboriginal women aged 65 and older, compared with 50% of their Canadian counterparts, were diagnosed with arthritis (Canadian Arthritis Society, 2004). While these statistics are based on comparisons between the Canadian population and on-reserve Aboriginal women, similar trends in arthritis prevalence are found within the urban, off-reserve Aboriginal population (Canada, 2003).

While the information and statistics presented above help paint a picture of the burden of arthritis in Aboriginal populations, a brief discussion of osteoarthritis is included here to highlight the specific burden of this type of arthritis in Aboriginal populations and to help lead into a discussion of osteoporosis.

5.2.1 Osteoarthritis

Osteoarthritis (OA), also known as arthrosis, degenerative arthritis, degenerative joint disease, and the “wear and tear” arthritis, is the most common form of arthritis. It is caused by a breakdown in the cartilage, which covers and acts as a cushion inside joints, and destruction or decrease of synovial fluid that lubricates those joints. While osteoarthritis can affect any joint, it usually affects the peripheral joints (i.e. hips, knees, hands and spine) (Dictionary, 2002). While osteoarthritis is thought to be largely hereditary, aging joints, previous injuries, and obesity are thought to exacerbate risk.

As noted above, OA is the most common type of arthritis, affecting 10 % of Canadian adults (Canada, 2003). While the literature on OA is limited in Aboriginal populations, Thommasen (2006) has noted that rural Canadians and rural Aboriginals are the most vulnerable for OA (Thommasen, 2006). Earlier studies (1960-61) of OA in North American Native populations found that 68% of Blackfoot Indians, 65% of Pima Indians, and 24% of Alaska Eskimos had OA of the hands (Peschken & Esdaile, 1999). These rates are particularly high considering that the same study showed that 7-12% of the White populations with OA in 1968 (Peschken & Esdaile, 1999). A 1986 study, however, reported much lower OA prevalence rates Inuit men (1%) and Inuit women (2%) (Peschken & Esdaile, 1999). Gender specific prevalence of hip OA was found

to be similar in Aboriginal and non-Aboriginal populations, being less than 10 % in all age and gender groups (Hirsch, 1998). In Australian Aborigines, OA appears to be particularly common in the temporomandibular joints, right elbow and knees (Roberts & Roberts-Thomson, 1999).

As this data only provides a superficial view of the burden of osteoarthritis in Aboriginal populations, it will be worthwhile to engage with the mainstream arthritis literature and examine the prevalence and risk for arthritis, and particularly osteoarthritis, in Aboriginal populations.

5.3 Osteoporosis

Osteoporosis is defined and diagnosed by the World Health Organization (WHO) in women as a bone mineral density (BMD) 2.5 standard deviations below peak bone mass (20-year-old healthy female average) as measured by Dual energy X-ray absorptiometry (DXA) (Lewiecki, 2006; World Health Organization, 1994);(Leslie, 2006; Skye Nicholas, 2002). While this testing is commonly used, some researchers have voiced doubts about the accuracy of osteoporosis diagnosis among children, men and women of other ethnic groups when based on the WHO criteria (Skye Nicholas, 2002). The term “established osteoporosis” is used to refer to the increased presence of fragility fractures (World Health Organization, 1994).

Overall, the data on osteoporosis in Aboriginal populations is limited. The most available studies of osteoporosis related to and report on fracture rates, without data on or reference to mean BMD values. As such, it is difficult to estimate whether elevated fracture rates in these populations are related to osteoporosis or to other factors, such as high risk activities, falls due to age, qualitative changes in bone structure, and variability in bone geometry (Skye Nicholas, 2002). Keeping these other potential fracture factors in mind, a recent retrospective, population-based, matched cohort study of fracture rates in Manitoba’s Aboriginal and non-Aboriginal populations has reported higher rates of hip, wrist and spine fractures in Aboriginal versus. non-Aboriginal population (Leslie, 2006). This data is provided in the table below.

Table 1. Fracture rates in Aboriginal and non-Aboriginal Manitoba adults (age 20 years and older), 1984-2003

Fracture site	Aboriginals	Non-Aboriginals
Hip	1.1 %	0.6 %
Wrist	1.3 %	0.5 %
Spine	1.6 %	0.9 %

Source: (Leslie, 2006)

As there is not a lot of information on osteoporosis in Aboriginal population, future studies are warranted to unpack the underlying burden of this disease among Aboriginal Peoples in Canada. The potential for higher rates of osteoporosis due to linkages with other chronic diseases and risk factors in Aboriginal populations, such as obesity and diet, make this an important area for future research.

6. The Burden of Cancer in Aboriginal Populations

6.1 Definition and Description of Cancer

Normally, the human body is made up of billions of cells that develop in predictable ways. Cancer is caused when those cells begin to develop unpredictably: it is characterised by uncontrolled growth and spread of abnormal cells in the body (PHAC). Cancer is not one disease, but is a group of more than 100 different and distinctive diseases. Cancer can involve any tissue of the body and have many different forms in each body area. Most cancers are named for the type of cell or organ in which they first develop. Cancerous cells are most often detected when they begin to lump together and form a mass, commonly known as a tumour. As the tumour grows, it may damage and/or takeover nearby tissue and metastasize (spread) into another part of the body (About.com, 2007).

Documentation of cancer mortality and incidence rates largely indicate that cancer is less prevalent among Aboriginal People than it is among Canada's general population (Waldram et al., 2006). Because determining the exact prevalence of cancer in Aboriginal populations is a challenging task, the reliability and accuracy of the current statistical data is limited (First Nations and Inuit Regional Health Survey National Steering Committee, 1999). Taking this into consideration, this section will begin by outlining several of the surveillance methods used to examine cancer in Aboriginal populations. A presentation of the current data on cancer prevalence will follow this discussion.

6.2 Cancer Surveillance in Aboriginal Populations

All Canadian provinces are equipped with population-based cancer registries that report data on the number of cancer cases within their population (Waldram et al., 2006). The challenge with determining the incidence and prevalence of cancer in Aboriginal populations is that most of these provincial registries do not report cancer data by ethnicity (First Nations and Inuit Regional Health Survey National Steering Committee, 1999). Further, Statistics Canada does not compile or report on cancer data by ethnic status (Waldram et al., 2006).

Nevertheless, there are several surveillance methods that are used to study cancer in Aboriginal populations. These methods include: gathering information using residence codes for reserves; using First Nations indicators in health insurance numbers; using the ethnicity recorded on death certificates; or through linking the data with the Status Verification System. The problem with these surveillance methods, however, is that they can include inappropriate individuals or exclude appropriate individuals in the registry, thus, producing biased results (Marrett, Jones, & Wishart, 2004). For example: the use of residence codes may include non-Aboriginal people living on reserve, exclude urban Aboriginals and other off-reserve Aboriginals, and also exclude individuals who may have had to leave their home community to receive treatment (Rosenberg & Martel, 1998). The use of provincial health card numbers is troublesome because not all health card numbers have First Nations indicators. Finally, death certificate ethnicity data is often inaccurately recorded and the Status Verification System is not always up to date (Marrett et al., 2004). Due to these concerns, other methods of studying disease burden in Aboriginal populations would be beneficial, as would creating specific Aboriginal cancer registries regionally and/or nationally.

A specific registry that has been established is a Canadian Inuit cancer registry comprised of cases from the Northwest Territories, Nunavik, and Labrador (Gaudette et al., 1996). This unique registry was developed as part of an international circumpolar review of cancer among Inuit populations (Gaudette et al., 1996). While the Northwest Territories and Nunavut both have current cancer registries, this collaborative Inuit registry does not undergo maintenance or updating (Waldram et al., 2006).

Consequently, data on the burden of cancer in Aboriginal populations is obtained by developing linkages between ethnicity and provincial registries. National data is obtained by linking the provincial data together. While there are problems with this reporting system and data sources, it is important to review the information gained through them. Prior to a discussion of the burden of cancer in Aboriginal populations, it is important to explain that in addition to a faulty registry system, very few Canadian studies that have been published to date are restricted in their generalizability and validity beyond the very source of the information. Such other limitations are summarized well by Marrett & Chaudhry (2003):

The limitations include small numbers of cancers, different methods of identifying cancers in FN [First Nations] people versus the general populations groups, numerators and denominators derived from different sources, lack of currency in terms of the years studied, and restricted populations (for example, only those on reserves). Further, few have had the numbers and length of study period to be able to examine changes in cancer patters over time (p. 259).

Taking these limitations into account and the fact that there are only a handful of studies on cancer incidence and mortality published in Canada (Marrett & Chaudhry, 2003), the following section will try and summarize the general information on the burden of cancer in Aboriginal populations.

6.3 Burden of Cancer in Aboriginal Populations

While there are only a few studies on the burden of cancer in Aboriginal populations, the vast majority of them focus on First Nations People (Marrett & Chaudhry, 2003). Information has also been documented on the Inuit population (Gaudette, Gao, Freitag, & Wideman, 1993; Nielse, 1996) and even less specifically focused on the Métis population (Kliwer, Mayer, & Wajda, 2002). Because of the differences in the amount of literature and the burden of disease among the three different Aboriginal groups in Canada, they will be reviewed separately below.

6.3.1 Burden of Cancer among Canada's First Nations population

Data collected in the 1970's from British Columbia (Gallagher & Elwood, 1979), northwestern Ontario (Young & Frank, 1983), and Manitoba (Young & Choi, 1985) all reported lower incidence rates for First Nations people when all cancer sites were combined (Waldram et al., 2006). However, a study by Rosenberg and Martel (1998) that examined time-trend from 1972-76 and 1987-91 noted that cancer incidence and mortality appear to be increasing on reserves. They found that while cancer incidence has been traditionally lower in First Nations populations, cancer incidence and pattern of survival were found to be similar to that of the general population, except for a higher proportion of cases and mortality caused by cervical and gallbladder cancer in females and kidney cancer in both sexes (Rosenberg & Martel, 1998).

Marrett and Chaudhry (2003) reported similar trends in their study of cancer incidence and mortality among Ontario First Nations people between 1968 and 1991. They reported that cancer incidence was significantly lower in Status Indians, compared to the general population, for some of the most common cancers (i.e. breast, lung, prostate, and colorectal) (Marrett & Chaudhry, 2003). Despite these comparatively lower rates, the incidence rates for all types of cancer increased significantly over the time periods of the study. Other less common cancers, such as cervical, gallbladder, and kidney, were exceptions to this trend: cancer of the gallbladder is twice as common in Status Indian men and women than it is in the general population; cervical cancer is 1.73 times higher in Status Indians than in the general population and is the second most common cancer in Indian women; and, kidney cancer appears to occur more frequently in Status Indian populations, but the rate for both sexes was not statistically significant (Marrett & Chaudhry, 2003). This and other key information gathered in Marret and Chaudhry's (2003) study and its comparison with the other major studies conducted in provinces across the country are summarized in the table below.

Table 2. Cancer incidence, prevalence, and mortality in Ontario, Manitoba, Saskatchewan, and British Columbia

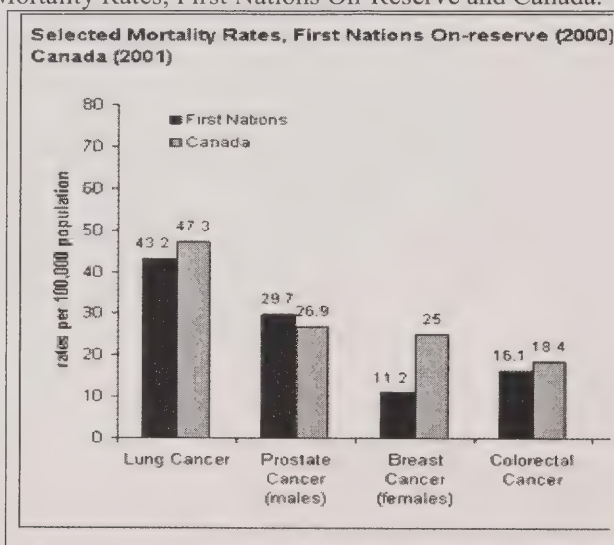
Province	Related Literature	Cancer incidence, prevalence, and mortality
Ontario	(Marrett & Chaudhry, 2003; Young & Frank, 1983)	<ul style="list-style-type: none"> • Incidence of kidney, mouth, throat and stomach cancers is similar in Aboriginal and non-Aboriginal populations for both sexes; • Incidence of colorectal cancer is equivalent in Aboriginal and non-Aboriginal male populations; • Incidence is increasing in Aboriginal populations for the leading cancers, such as breast, prostate, lung and colorectal, and is approaching overall Ontario cancer rates; • Incidence for cervical cancer is declining in female Aboriginal populations, and is approaching the Ontario rate for women; • Survival rates are significantly lower in Aboriginal populations, compared to the non-Aboriginal population, for all cancers combined, for prostate cancer in Aboriginal men, and for breast cancer in Aboriginal women; • Survival rates are similar in Aboriginal and non-Aboriginal populations for other leading cancers (lung, colorectal and cervix).

Manitoba	(Young & Choi, 1985)	<ul style="list-style-type: none"> Aboriginal women have higher incidence of cervical cancer than non-Aboriginal women; The incidence rate of kidney cancer is higher in the Aboriginal population.
Saskatchewan	(Gillis et al., 1991)	1. Survival for breast cancer is poorer in the northern Aboriginal population than in the southern non-Aboriginal
British Columbia	Threlfall et al, 1986	<ul style="list-style-type: none"> Aboriginal women have a higher incidence of cervical cancer than non-Aboriginal women; Pancreas and stomach cancer incidence rates in the Aboriginal population is similar to that of the BC population; Survival rates for all cancers combined is similar in both Aboriginal and non-Aboriginal populations.

Information gathered from (Marrett & Chaudhry, 2003). As this table shows, the amount and type of information available in each province varies greatly.

In an attempt to get a national perspective, the leading cancer mortality rates in on-reserve First Nations and the general Canadian population were compared by Statistics Canada in 2000 and 2001. These analyses found that First Nations cancer mortality rates, except for male prostate cancer, were lower than those for the overall Canadian population (Statistics Canada). This is demonstrated in the figure below.

Figure 3. Selected Mortality Rates, First Nations On-Reserve and Canada.



(Statistics Canada)

While these lower rates are encouraging, the literature reviewed above indicates that cancer rates are increasing in First Nations populations and are quickly approaching cancer rates in the Canadian general population (Marrett, 2003).

6.3.2 *Burden of Cancer among Canada's Inuit population*

The burden of disease among Canada's Inuit population is quite different from that noted among Canada's First Nations. For example, it has been reported that Inuit people are at a high risk for several rare cancers, including nasopharyngeal, salivary gland, and esophageal cancer (Gaudette et al., 1993; Waldram et al., 2006). Since the 1970's, however, these "traditional Inuit cancers" (Waldram et al., 2006) have declined, while more common cancers among the general population, such as lung, cervical, colon, and breast cancers, have increased (Hildes & Schaefer, 1984; Schaefer, Hildes, Medd, & Cameron, 1975).

Cancer data collected during the time period of 1969-1988 from Greenland, Canada and Alaska provide important insights into the study cancer patterns of Circumpolar Inuit populations (Nielse, 1996). For instance, the results of this international, collaborative study demonstrated that the age-standardized rates increased by 22% for Aboriginal men and 24% for Aboriginal women from 1969 to 1988, which did not deviate significantly from cancer rates observed in the mainstream populations of Canada, Denmark and Connecticut (USA) (Nielse, 1996). However, significant differences between Inuit populations and the comparison populations were found in the site-specific cancer rates. Compared with the populations of Canada, Denmark and Connecticut (USA), the Inuit were found to be at higher risk of lung, nasopharynx, salivary glands, oesophagus, gallbladder and extrahepatic bile ducts cancers. Inuit males had a higher incidence rate for cancer of the liver and stomach, while Inuit females were at higher risk of cervical and renal cancer. The leading cancer sites in Circumpolar Inuit males and females are represented in Table 3 below.

Table 3. The Leading Cancer Sites in Circumpolar Inuit (1969-1988)

Leading Cancer Sites in Circumpolar Inuit (1969-1988)				
Male population			Female population	
1	Lung	28.3%	Cervix	17.6%
2	Colon	8.1%	Lung	13.7%
3	Stomach	7.0%	Breast	11.4%
4	Nasopharynx	6.5%	Colon	9.6%

(Nielse, 1996)

While Circumpolar Inuit populations have reportedly high levels of certain cancers, they are also at lower risk for cancer of the bladder, breast, endometrium, prostate, as well as for lymphomas, Hodgkin's disease, leukemia, multiple myeloma and melanoma (Nielse, 1996). Investigations into the underlying reasons for differences in prevalence among the Inuit will be important to investigate in future research.

6.3.3 *Burden of Cancer among Canada's Métis population*

Very little information is available on the health status of Métis people in Canada, particularly with regards to cancer. In order to find ways to develop a pool of information on the burden of cancer among Manitoba's Métis population, the Manitoba Métis Federation (MMF) approached CancerCare Manitoba to discuss information sharing and develop a dataset (Kliewer et al., 2002). As was discussed in the beginning of this section, databases maintained by provincial organizations do not have specific ethnic or racial indicators (First Nations and Inuit Regional Health Survey National Steering Committee, 1999). A pilot study done to assess the feasibility of linking a sample of the MMF membership list to Manitoba Health (the provincial database) and CancerCare Manitoba databases in order to retrieve more concrete information on the health status of Métis (Kliewer et al., 2002). As the data used to calculate the prevalence of cancer in this study consists of small numbers, it is not possible to report extensively on cancer site. It is possible, however, to discuss some preliminary observations about the burden of cancer among the Métis in Manitoba gained from this study (Kliewer et al., 2002).

Out of the study sample, six (6) males and twenty (20) females were diagnosed with cancer in 1995-1997. Overall, this meant that the average annual age-standardized cancer incidence rate was lower for Métis men as compared to the general male Manitoban population. The incidence for Métis women was slightly higher than the general female Manitoban population. The rate of cervical cancer was found to be substantially higher among Métis women. The crude age-standardized prevalence rates for Métis women were lower for Métis women. When age-specific prevalence rates were taken into account, however, the prevalence was higher for Métis women than it was for all Manitoba women. The prevalence of malignant and other neoplasms were slower for Métis men than for the general population, while malignant neoplasms were higher in Métis women and other neoplasms were comparable to the general female Manitoba population. This overall high prevalence of cancer in Métis women is attributed to the substantially higher rates of cervical cancer as compared to Manitoban women. This is comparable with studies of cervical cancer reported for Manitoba's Treaty Status Indians (Young, Kliewer, Blanchard, & Mayer, 2000).

While this brief discussion of cancer rates among the Métis in Manitoba begins to paint a picture of the burden of cancer among Métis peoples, its limitations as a pilot study and its provincial location highlight that further information and data is needed.

7. Burden of Severe Mental Illness in Aboriginal Populations

7.1 Definition and Description of Chronic Mental Illness

Mental illnesses have been defined as "states of distress that result from complex interactions between person and environment over the course of decades of individual development" (Spaulding, Sullivan, & Poland, 2003). Defining mental illnesses as 'chronic,' however, is an issue of much debate. This is largely because of questions about the meaning of the term 'chronicity.' For instance, does chronicity refer to the duration of symptoms, the functional disabilities that result from mental illness, or both? (Bachrach, 1988; Soreff, 1996) If both, are duration and disability equally important in determining chronicity? Further, is chronicity established after a specific duration of persistent illness or after a certain number of recurrent

episodes? (Soreff, 1996) There is also a question of whether chronicity can be inferred from the diagnoses of particular mental disorders (Bachrach, 1988). Nevertheless, there is general agreement among researchers that diagnosis is “a necessary but not sufficient condition for defining chronic mental illness” (Bachrach, 1988).

The use of the word ‘chronic’ has also raised the concerns of mental health advocates who believe the term implies and perpetuates a sense of hopelessness with regards to the management and treatment of severe mental illnesses (Bachrach, 1988). Labelling an individual as chronically mentally ill can be perceived to limit that person to a continuous or life-long illness (Bachrach, 1988; Lefley, 1990; Soreff, 1996). To avoid the stigma associated with the word ‘chronic’, the phrase ‘severe and persistent mental illness’ or simply, severe mental illness (SMI) is more commonly used, and will be used here.

Despite the many challenges of defining SMI, some researchers have attempted the task. Stein (1995) defined SMIs as “those illnesses that are longer than one year in duration, cause significant dysfunction, and meet certain diagnostic criteria” and likewise, Rosenberg and colleagues (2005) defined SMI as “a diagnosis of a major mental illness, disability in important life spheres (e.g. school, work or family function), and persistence of illness and disability”. Soreff (1996) provided a broader definition, that is, the “severe and persistent disabilities that result primarily from mental illness” and acknowledged the vast differences that exist in the duration of illness and degree of disability that influence diagnosis. Indeed, “those who might be defined as chronically mentally ill today vary widely in their diagnoses, their treatment histories, their functional levels, and their treatment needs” (Bachrach, 1988). Taking these differences into consideration will be important as we review the burden of severe mental illnesses in Aboriginal populations. This is because the limited literature on mental illness in Aboriginal populations and in limited contexts in which it has been examined can encourage an over-generalization of findings and present a limited perspective.

7.2 Burden of Severe Mental Illnesses in Aboriginal Populations

Although there is some disagreement over which mental disorders qualify as severe and persistent, schizophrenia, bipolar disorder and major depressive disorder are generally categorized as such (Bachrach, 1988; Rosenberg et al., 2005; Stein, 1995). Therefore, these disorders should be included in this discussion of the SMIs that affect Indigenous individuals. Unfortunately, the limited research available on bipolar disorder among Indigenous Peoples hinders our ability to discuss the topic. This shows, without a doubt that research in this area would be of value. Nonetheless, Indigenous experiences of schizophrenia and major depressive disorder, as well as post-traumatic stress disorder and addiction, will be discussed below. While literature related to Canadian contexts is used wherever possible, a lack of specific studies on mental health in Canada’s Aboriginal population means that studies from other Indigenous populations is used to supplement the Canadian material. As important lessons about prevalence, burden and treatment of SMIs can be learned from Canada’s international counterparts, these discussions will be informative for the Canadian context.

7.2.1 Schizophrenia

Early studies of schizophrenia have indicated that there are differences in the incidence and expression of symptoms between Indigenous and non-Indigenous patients. For instance, Bates

and Van Dam (1984) found a much lower incidence of schizophrenia among First Nations of coastal British Columbia than the Caucasian population, though incidence rates were not equal across all First Nations groups. Mowry and colleagues (1994) noted that among persons diagnosed with schizophrenia in Western Australia, Australian patients varied significantly from non-Indigenous patients in the diagnostic symptoms reported in their medical records. The authors suggested a number of possible explanations for the differences, including: misinterpretation of symptoms by mental health professionals; bias in clinical examination and record keeping; unique manifestation of schizophrenia among Indigenous patients; or misdiagnosis of Indigenous patients suffering from alternative mental illnesses (Mowry et al., 1994).

Recent research on schizophrenia in Indigenous populations is limited; however, the studies that do exist both contradict and support earlier research on the topic. Researchers in New Zealand reported Maori to be over-represented among adolescents who self-reported schizotypal symptoms (i.e., magical thinking, hallucinatory tendency, self-referential ideation, and perceptual aberration) (Linscott, Marie, Arnott, & Clark, 2006). Conversely, Robin and colleagues (2007) reported that for two North American Indian tribes, the prevalence of schizophrenia matched that expected for the general population, and among second-degree relatives of individuals with schizophrenia, the prevalence was lower than expected. The authors acknowledged that the prevalence rate of schizophrenia was not higher for these tribes despite the increased risk associated with the high prevalence of alcohol consumption, drug use and poor socioeconomic conditions within the tribal communities. They conclude that psychiatric misdiagnosis, reliance on small sample sizes, and limited cultural awareness have lead to over-estimation of the prevalence of schizophrenia among North American Indians (Robin et al., 2007). Therefore, socio-cultural factors must be considered prior to making a diagnosis of schizophrenia (Robin et al., 2007). Overall, it is clear that there is no prevalence rate of schizophrenia consistent across all Indigenous groups. When prevalence rates do differ from those of non-Indigenous populations, these differences may have less to do with biological differences and more to do with the diverse cultural influences of Indigenous Peoples.

As the above discussion demonstrates, more targeted research on schizophrenia in the Canadian context is needed. Further, research into and discussion of treatment, potential interventions, and ways to improve the health and well-being of individuals living with schizophrenia would be beneficial.

7.2.2 Depression

There is some debate as to whether depression is a chronic illness or not (Gask, 2005; Parker, 2005; Van Weel-Baumgarten, 2005). 'Depression' and 'major depression' are terms that oversimplify and gloss over the multitude of causes, expressions, trajectories, and outcomes of the various depressive disorders that exist (Parker, 2005). Given the effect that a patient's history, help-seeking behaviour, social environment, and compliance can have on their response to treatment; as well as the influence of a health practitioner's skills, priorities, biases, and preferred treatment methods; it can be argued with reason that for some individuals the experience of depression is chronic and for others it is not (Van Weel-Baumgarten, 2005).

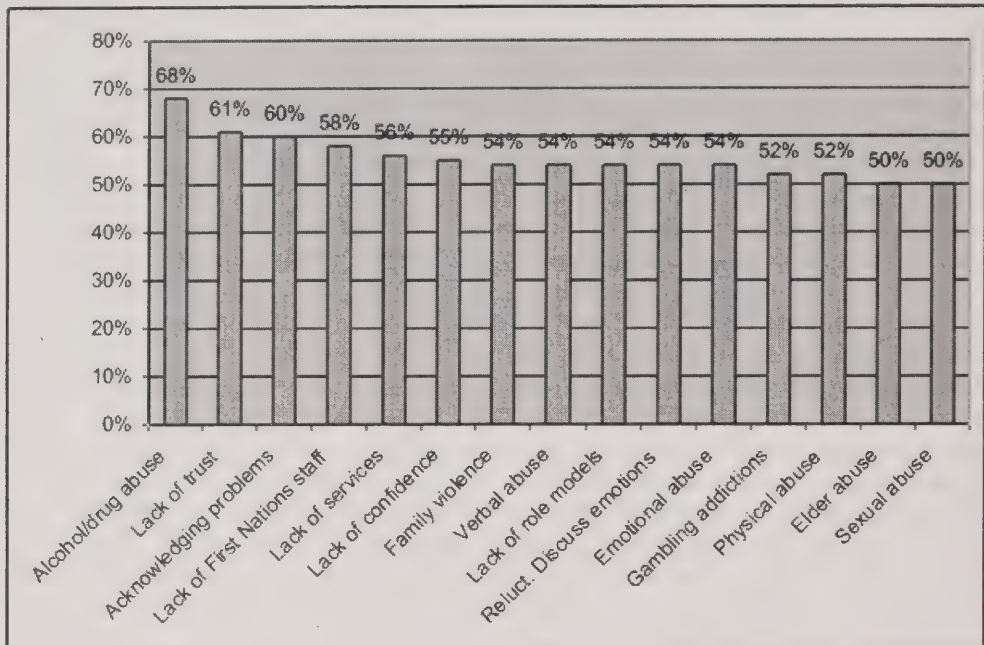
Depression is often assumed to be prevalent among Indigenous Peoples because of high suicide rates in some communities (Thommasen, Baggaley, Thommasen, & Zhang, 2005); however,

reports of depressive episodes among Indigenous Peoples vary considerably. Further, reports of depression among Aboriginal Peoples in Canada are almost exclusively restricted to First Nations, with little information for Métis, Inuit, and non-Status Natives (Health Council of Canada, 2005). Even the information we have on First Nations is largely self-reported in surveys and, therefore, only offers a crude estimate of depression rates with no information regarding specific mental disorders. In an effort to get a better understanding of the depression among Aboriginal Peoples, this section will review the literature available in Canada and internationally. Data from the 2000/2001 Canadian Community Health Survey revealed that 13.2% of the Canadian off-reserve Aboriginal population had experienced a major depressive episode in the past year, a rate 1.8 times that of the non-Indigenous population; however, similar depressive rates were found between Indigenous and non-Indigenous peoples living in the Canadian territories as well as between those with high and low household incomes (Tjepkema, 2002). Another Canadian survey, the 2002/03 Regional Health Survey, found that 30.1% of adult and 27.2% of youth First Nations respondents had felt sad, blue, or depressed for a period of two weeks or more in the year prior to the survey (First Nations Centre, 2005). Those respondents reported suicide ideation and attempts twice as often as respondents who did not feel sad, blue or depressed. Research conducted by the Government of Canada found that approximately 8% of Canadian adults experience major depression at some time in their lives (Health Canada, 2002) compared to 12% reported by First Nations in 2001 (Government of Canada, 2006). A comprehensive study of depression, anxiety and use of antidepressant medication in the Bella Coola Valley of British Columbia revealed that the prevalence rate of depression-anxiety disorders among Indigenous people was slightly lower, though not significantly different, than the prevalence rate among non-Indigenous people (Thommasen et al., 2005). Other studies however have not found a statistically significant difference between Aboriginal and non-Aboriginal people in terms of depression rates (Thommasen, Baggaley, Thommasen, & Zhang, 2005). In contrast, a study conducted in the United States of American Indians of Northern Plains and Southwest tribes were found to be at lower risk for 12-month and lifetime major depressive episodes than individuals sampled from the general population, though significant differences in risk were found between the two tribes and between men and women of the tribes (Beals, Novins, Spicer, Mitchell, & Manson, 2005). Among a sample of Navajo American Indians, 37% had experienced a major depressive episode in their lifetime, 11% reported current depressive disorders, and one-fifth (20%) had experienced depressive, anxiety and substance use disorders in their lifetime (Storck, Csordas, & Strauss, 2000). The variations that exist in the depressive experiences of Indigenous Peoples suggest that, similar to the general population, depression will be chronic for some individuals and not others.

Some Canadian research has examined the manifestation of depression among Aboriginal Peoples. Kirmayer and colleagues (1994) reported symptoms among the Inuit of Nunavik analogous to the ICD 10 diagnostic criteria for depressive episode including: wanting to be alone, refusing to talk with others, not eating, not sleeping, and crying a lot. Söchting, Corrado et al. (2007) suggested that the symptom picture among Aboriginal people seeking mental health services is often quite extreme in terms of impairment in interpersonal relations, poor self-image, inability to regulate and control intense negative emotions, and serious substance abuse (Söchting et al., 2007). Some have suggested that the traditional means of coping with stress and psychological pain have changed in recent times to impulsive behaviour and substance abuse (Kirmayer et al., 1994). Among Aboriginal men, many avoid medical health services and cope

with their depression by drinking alcohol or hunting (Government of Canada, 2006; Kirmayer et al., 1994). The use of alcohol as a means of dealing with trauma among Indigenous peoples is also explored in American research. Brave Heart (2003) identifies alcohol use as a way of avoiding painful feelings through self-medication. The important influence that alcohol and drug abuse has on one's mental health is evident in the figure below, which list the factors considered by First Nations living on reserve in Saskatchewan very important to maintaining mental health (First Nations Centre, 2004).

Figure 4. Factors considered very important in maintaining mental health



Source: 1997 RHS Saskatchewan results (First Nations Centre, 2004)

Indigenous social and cultural factors can influence the chronicity of an Indigenous individual's depressive experience. For example, in Australia where nearly three-quarters (72%) of an Indigenous sample indicated that depression was an inborn characteristic of an individual that could not be resolved through treatment, depressive experiences may be chronic more often than not (Vicary & Westerman, 2004). Yet in the United States, Navajo patients who described cultural causes and interpretations of their depressive experiences were able to reach remission (i.e., a sense of balance and well-being and reduction of depressive symptoms) through individualized, culturally-appropriate healing practices (Storck et al., 2000). Thus, not only is treatment "dependent upon the cultural explanation given to the illness" (Vicary & Westerman, 2004), but the outcome of the treatment is dependent upon culture as well.. For instance, because of the evidence for non-medical means of coping with depression, depression rates estimated from service utilization data for Aboriginals are likely underestimates of the true prevalence of depression (Kirmayer, Brass, & Tait, 2000). Data from the 2002/03 Regional Health Survey state

that 71.7% of individuals feeling sad, blue or depressed ranked family and friends as their top choices of support. Only 9.1% and 8.4% ranked psychiatrist or psychologists as a support (Committee, 2005). More research is required in this area in order to ascertain how detection methods should be altered to make them more appropriate (Jackson-Triche *et al.*, 2000).

7.2.3 Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a psychological disorder that arises from an individual's experience of trauma (Chansonneuve, 2007; Corrado & Cohen, 2003; Mitchell & Maracle, 2005). A diagnosis of PTSD requires the following symptoms to be present: re-experiencing the traumatic event (such as flashbacks or nightmares), avoidance of stimuli associated with the traumatic event, and increased physiological arousal (such as rapid breathing and increase heart rate). Affects on the mind, emotions, body, and spirit include: anxiety; intrusive thoughts and memories; sleep disturbances; angry outbursts; exaggerated startle response; and hyper-sensitivity. It is not uncommon for PTSD to exist in concurrence with additional mental and physical health problems such as depression, substance abuse, heart disease, and stomach problems (Corrado & Cohen, 2003; Mitchell & Maracle, 2005).

The availability of prevalence rates of PTSD among Canada's Aboriginal population, and even Indigenous Peoples worldwide, is limited. The majority of research on PTSD in Indigenous populations sampled from adult American Indians of Southwest and Northern Plains tribes. Veterans of these tribes were more likely to qualify for diagnosis of lifetime and current PTSD than Caucasian veterans (Beals *et al.*, 2002). The prevalence of lifetime PTSD for adults of the Southwest tribe was 21.9%, and was higher for women (25.4%) than for men (17.9%) (Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997). In the Northern Plains tribe, 15% of the sample met criteria for lifetime PTSD, and the participants who met PTSD criteria were more likely to be diagnosed with lifetime major depressive disorder and alcohol abuse than those who did not (Sawchuk *et al.*, 2005). The high prevalence rates of PTSD found among adults of these tribes were attributed to high rates of exposure to traumatic events and not to any increased vulnerability of American Indians to PTSD (Robin *et al.*, 1997; Sawchuk *et al.*, 2005). One research group found that among a sample of American Indian adolescents in substance abuse treatment, the proportion of participants that met criteria for PTSD (10.3%) was modest in comparison to the proportion that had traumatic experiences (98%) (Deters, Novins, Fickenscher, & Beals, 2006). The authors suggested that future research should explore the resiliencies that Indigenous youth develop in the face of repetitive traumas.

A minority of Indigenous survivors of the residential school system present diagnostic symptoms similar to those of post-traumatic stress disorder, while many others struggle with commonly associated symptoms, such as relationship difficulties, deficient parenting skills, little knowledge of Indigenous culture, reduced interest and participation in cultural activities, and alcohol or drug abuse associated with violent outbursts (Brasfield, 2001; Corrado & Cohen, 2003; Dion Stout & Kipling, 2003). The term 'residential school syndrome' is sometimes used to describe this group of symptoms, though the term remains controversial because specific diagnostic criteria has not yet been formally established (Brasfield, 2001). Furthermore, Chrisjohn and Young (1995) argue that a regular set of symptoms associated with attendance at residential schools is unlikely to exist due to the wide range of experiences and behaviours of residential school survivors. Research on PTSD among Indigenous groups should be regarded with similar caution, as the present symptoms are likely to vary significantly from individual to individual, as well as

between Indigenous and non-Indigenous populations, as a result of unique histories, experiences and coping strategies.

7.2.4 Addiction

Much like other mental disorders, addiction lacks an established definition and clear diagnostic criteria. Sometimes, addiction is confused or used interchangeably with other terms, such as dependence or compulsion. For the purposes of this discussion, addiction is defined as “a process whereby a behaviour, that can function both to produce pleasure and to provide relief from internal discomfort, is employed in a pattern characterized by: (1) recurrent failure to control the behaviour (powerlessness) and (2) continuation of the behaviour despite significant negative consequences (unmanageability)” (Goodman, 1990). Addiction is not synonymous with dependence (gratification of needs) or compulsion (evasion or avoidance of internal discomfort), but instead involves both dependence and compulsion together (Goodman, 1990). Addictive behaviours may also include gambling, overeating, working, or using psychoactive substances

Although addiction to a psychoactive substance involves abuse of a substance, the abuse of a substance is not always addictive ([NNAPF], 2000). Often, substance abuse occurs infrequently or in an experimental setting; however, this pattern may not hold true for all populations. Research suggests that patterns of substance abuse differ between Indigenous and non-Indigenous populations (Beauchamp et al., 2004; First Nations Centre, 2005; Fournier & Crey, 1997; Health Canada, 2003; Sargers & Gray, 1998; Thommasen, Hanlon, Thommasen, & Zhang, 2006). Most studies of substance use among Indigenous populations have focused primarily on the use of tobacco and alcohol. It can be argued that tobacco abuse poses the greatest long-term consequences to Indigenous health, yet, for many Indigenous communities, the immediate health and social consequences of alcohol abuse are of primary concern (Sargers & Gray, 1998). Because we will focus on tobacco use (and potential abuse) later in the book, as it is a major risk factor across the life course for many other chronic diseases, this discussion of addiction will focus on alcohol addiction.

Alcohol Addiction

The disease model of alcoholism, which defines alcohol addiction as a chronic disease, is supported by many but regarded as limited by others. For example, Alcoholics Anonymous, which has wide-reaching influence on how alcohol addiction is viewed and treated, endorses the disease model of alcoholism (Suissa, 2003). Many people have found comfort and social support through accepting this view of alcohol addiction, and have been successful in attaining and maintaining sobriety. Suissa (2003) has argued that the disease model is also supported by specific groups, including Irish and Indigenous groups, because it fits with their cultural understandings of alcohol and addiction. However, the ‘all-or-nothing’ orientation of the disease model, which when applied to alcohol addiction means an “individual is or is not an alcoholic forever” (Suissa, 2003), is limited by its applicability and treatment options. For instance, ‘all-or-nothing’ demands that alcoholics abstain from alcohol. Unfortunately, such a view can overlook the benefits to be gained from brief intervention and harm reduction strategies. In addition, ‘all-or-nothing’ cannot be applied universally across addictions; an individual addicted to overeating cannot abstain from eating, just as a workaholic cannot abstain from working (Goodman, 1990).

Thus, living with or overcoming addiction can sometimes require more than simply abstaining; addicted individuals may need to learn skills that facilitate healthy moderation instead (Goodman, 1990).

Nonetheless, abstinence has helped many alcohol addicted Indigenous individuals to achieve a healthy and well-balanced lifestyle. Much of the existing research on Indigenous alcohol use has found that abstinence and lower frequency of use are more common among Indigenous Peoples than non-Indigenous people (First Nations Centre, 2005; Fournier & Crey, 1997; Siggers & Gray, 1998; Thommasen et al., 2006). Often, a large portion of Indigenous abstainers are previous alcohol users (Siggers & Gray, 1998). Wardman and Quantz (2005) sampled from Indigenous Peoples of western Canada and found that most previous alcohol users described 'hitting rock bottom' before achieving abstinence. Often, binge drinking was used to numb the pain caused by physical and sexual abuse, low self-esteem, loss of culture and identity, and family history of substance abuse (Wardman & Quantz, 2005). Many of the individuals that were currently maintaining sobriety found strength through renewed spirituality and involvement in cultural traditions. In another study, narratives of Navajo men who previously drank but currently abstained from alcohol suggested that it was common for Navajo men to reach a point in life when issues of health, religion, family, and wealth took priority over alcohol use (Quintero, 2000). For these men, alcohol was associated with loss of tradition and an out-of-balance lifestyle. Often formal treatment was not sought, as the desire to return to traditional living was sufficient motivation to abstain.

It is also the case that, although the rate of abstinence is higher and frequency of alcohol use is lower, binge drinking occurs more frequently among Indigenous than among non-Indigenous alcohol users. In other words, "those who do drink tend to drink heavily" (Canada, 2006). It is likely this pattern of alcohol use that contributes to the alcohol-related problems experienced by Indigenous communities. This burden is exemplified by the fact that Alcohol was a factor in 6.4% of injuries incurred by First Nations youth and over one-quarter (27.1%) of assaults against First Nations youth (First Nations Centre, 2005). Rothe (2005) reported that within nine First Nations communities, respondents considered alcohol abuse and drinking and driving to be "normal, community-endorsed behaviours" (Rothe, 2005). The proportion of Status Indian deaths that are alcohol-related is nearly one-quarter (23.5%) while drug-induced deaths account for 6.2% of Status Indian deaths (Officer, 2002). High rates of alcohol-related morbidity and mortality have also been reported in Australia (Siggers & Gray, 1998). Reasons given by Indigenous individuals for their alcohol use include boredom associated with living in a communities of limited recreational and employment opportunities and need to self-medicate to anesthetize the pain of poverty, racism and violence; thus, it is more likely community social and economic structure rather than individual or cultural values that contribute to the high prevalence of alcohol abuse in Indigenous communities (Rothe, 2005).

7.3 Burden of Severe Mental Illnesses on Community Health

Community health is influenced by physical and social environments (Smye & Mussell, 2001) of both the past and present (First Nations Centre, 2005). Dysfunction within family and community life has wide-ranging influence on mental health (Mussell, Cardiff, & White, 2004) and an individual's experience of mental health can impact their family and community. Conversely, therefore, correcting relationships within the family and facilitating community

healing can promote health and wellness (Canada, 2006; Warry, 1998). As such, the following section will focus on the potential influence of SMIs on communities and the community-wide burden of disease.

When a population is marginalized and culturally suppressed, the mental health of that population, whether Indigenous or not, is affected at the individual, family, and community levels (Canada, 2006). Mental health problems often occur in the form of social burdens such as family violence, substance abuse and suicide (Canada, 2006; Warry, 1998), and although Indigenous communities differ in their response to the trauma of marginalization and oppression, many Indigenous communities have been plagued by problems of family violence, substance abuse, incarceration and suicide (Canada, 2006; Frank, 1992; Kirmayer, Simpson, & Cargo, 2003; Warry, 1998). The social and mental health problems that plague some communities are often interrelated and serve as indicators of larger family and community problems (Bohn, 2003; Frank, 1992). Issues of insufficient housing and infrastructure and poor access to recreational facilities are just a few examples of factors that contribute to the self-perpetuating cycle of collective trauma and destructive coping strategies through which community mental health problems persist (Canada, 2006; Dion Stout & Kipling, 2003). Through intergenerational transmission of social burdens, mental health problems can become problems that are not only severe and persistent across an individual's lifetime, but also chronic across generations within a community. Given this knowledge, it should come as no surprise that healing approaches focused exclusively on individuals have demonstrated limited effectiveness among Aboriginal populations (DeGagné, 2007; Mussell et al., 2004). Healing strategies must consider the burden individual behaviours have had on family and community life (Warry, 1998). Thus, while individual healing is important for overall community healing, the strategies that will be most successful in achieving community wellness will promote both individual and collective healing (First Nations Centre, 2005; Warry, 1998).

8. The Impact of Chronic Diseases on Mental Health

The experiences of people with chronic diseases are an important aspect of the chronic disease research literature. An important sub-set of the experiences of chronic diseases is the impact that having a chronic disease has on one's mental health. Thus, the association between chronic disease and mental illness will be discussed in this section. In doing so, it will address three key questions: (1) how are chronic diseases and mental health related? (2) Why are chronic diseases and mental health related? And, (3) to what extent are chronic diseases and mental health related?

8.1 Defining the parameters of the association between chronic disease and mental health

The association between chronic disease and mental illness is often discussed as the interconnection between chronic disease and depression. As discussed in the "severe mental illness" section, it is often questioned whether depression is actually a chronic illness. "Major depression" is often the term used to refer to chronic depression, as it has been noted that major depression has long-term effects on a patient's history, help-seeking behaviour, social environment, and compliance can have on response to treatment (Van Weel-Baumgarten, 2005). As depressive symptoms below the threshold for major depression have been found to have significant effects on daily function, and health care utilization (Sullivan *et al.*, 1999) and are

frequently precursors of more severe depression (Hammen, 1997). The prevalence of subthreshold depressive symptoms is at least equal to that of major depression and may be as much as two to three times that of major depression (Sullivan et al., 1999). As such, the interactions between chronic disease and all types of depression are important to examine. Following a discussion of depression, another psychological condition – adjustment disorder – that is related to the onset of chronic disease will be discussed.

8.1.1 Depression

The interconnection between chronic disease and depression is complex. Not only have some studies found that chronic diseases cause depression, but depression has been found to be independent risk factors for the development of certain types of chronic diseases. Depression is also associated with poorer outcomes, increased mortality and higher health care costs. The presence of depression influences health behaviours, making people less likely to make healthy lifestyle decisions or adhere to their medical treatment. Depression has been found to affect illness perceptions, making people who are depressed feel they are more ill than objective medical tests would predict. People who are depressed also have lower pain thresholds, making symptoms more painful than for an individual that was not depressed.

Depression can have direct physiological effects on disease such as in the case of diabetes, where depressive episodes have been associated with elevated glycemic levels. Among those with coronary heart disease, changes in lipid levels, physiological responses to stress and platelet function have all been explored for their relationship to depression (Davidson et al., 2006; Glassman & Shapiro, 1998; Hippiusley-Cox, Fielding, & Pringle, 1998; Lesperance, Frasur-Smith, & Talajic, 1996; Pratt et al., 1996). In addition, some drugs used to treat chronic diseases have been known to cause depression (Katon & Sullivan, 1990) and some drugs used to treat depression have been shown to affect chronic disease, as in the case of older classes of antidepressants which have coronary effects (Davidson et al., 2006; Pratt et al., 1996). Depression can be a symptom of a chronic disease, as in the case of stroke (Fava & Kendler, 2000) and depressive symptoms can be confused with the signs and symptoms of heart disease.

8.1.2 Adjustment Disorder

Another psychological condition related to the onset of chronic disease is adjustment disorder. Most patients with chronic disease do not have clinical depressions but rather suffer from an ‘adjustment disorder’ which is stress-related, time limited, non-psychotic disturbance that initiates within three months post stressor onset and resolves within six months (Casey, 2001; O’Keeffe & Ranjith, 2007; Rush, Polatin, & Gatchel, 2000). Adjustment disorder is a serious condition that affects up to one quarter of patients of any age without any pre-existing mental disorder (Casey, 2001; Strain *et al.*, 1998) and complicates the course of medical conditions (Casey, 2001).

Adjustment disorders are seen as an understandable but maladaptive response to a stressful event that resolves spontaneously when the stressor is removed or a new level of adaptation is reached (O’Keeffe & Ranjith, 2007). Diagnosis is made when the criteria for more specific diagnosis such as depressive episode or major or minor depression are not met (Casey, 2001; Casey *et al.*, 2006; Takei & Sugihara, 2006). Some clinicians prefer to diagnose adjustment disorder rather than other depressive disorders because of their unwillingness to ‘medicalize’ what they feel is a natural reaction to illness (Casey, 2001; O’Keeffe & Ranjith, 2007); this is despite the fact that

even the term adjustment disorder has been accused of pushing a human response to the realm of biomedicine.

Adjustment disorder encompasses serious mental symptoms and behaviours (Casey, 2001; Strain et al., 1998) that are indistinguishable from other depression disorders on the basis of symptom severity (Casey et al., 2006). Despite the fact that adjustment disorder shows similarly poor morbidity and mortality outcomes to those with other depressive disorders (Jones, Yates, Williams, Zhou, & Hardman, 1999; O'Keeffe & Ranjith, 2007), and that up to 15% of individuals go on to suffer a subsequent course of major depression (Takei & Sugihara, 2006), many clinicians are slow to provide treatment (Strain et al., 1998). Casey (2001) explained this lack of treatment by suggesting that most individuals with adjustment disorder recover quickly and completely making it unlikely that specific interventions are required (Casey, 2001). For example, among those suffering from heart attacks, the risk of death has been associated with recurrent depression rather than a single episode of major depression occurring for the first time after a heart attack (Lesperance et al., 1996). Depression is often more severe immediately following a myocardial infarction (MI) event and may be a transient reaction to the MI itself (Davidson et al., 2006).

However, in the time immediately following the onset of the disease it is not possible to distinguish those who will recover over time and those who will go on to develop a major depressive disorder. Evidence suggests that patients with adjustment disorder can benefit from treatment as much as patients with other depressive disorders (Jones et al., 1999) therefore treatment decisions must be balanced between the high prevalence of adjustment disorders, the significant time and resource required to treat them (Strain et al., 1998) and the potential benefits to the patient. Perhaps because of its inherently short duration and relatively high recovery rates, very little research has been done on this condition (Casey, 2001; Casey et al., 2006; O'Keeffe & Ranjith, 2007).

The distinction between the time-limited and disease-association of this disorder from major depression is critical. The fact that so little research has been done on this disorder and the failure of adjustment disorders to be incorporated into recent studies may have resulted in the prevalence of depressive disorders in many research studies involving medical illness to be misrepresented. Casey et al. (2006) suggested that the number of mild depressive episodes and combined depressive episodes are being conflated in relation to the number of adjustment disorders (Casey et al., 2006).

Some authors have argued that the exact language in diagnosing patients is not relevant to the management of these patients (O'Keeffe & Ranjith, 2007). Rather than focusing on whether a patient has adjustment disorder, major or minor depression, O'Keeffe argues that a better approach would be to ask "what are the patient's current problems and how can we deal with them?" (O'Keeffe & Ranjith, 2007). In this way, clinicians "would be able to use antidepressants for anhedonia, existential or spiritual approaches for demoralization, psycho-educational or cognitive approaches to deal with maladaptive adjustment and behavioural activation for poor motivation and learned helplessness, where indicated, in the same patient."

8.2 Unpacking the Association between Chronic Disease and Mental Health

The challenge with defining and describing the association between chronic diseases in mental health is that there are many possible mechanisms for interactions between the two health conditions. The table below, which is an abbreviated version of one presented in Prince, Patel et al. (2007), exemplifies this.

Table 4. Possible mechanisms for interactions between mental disorders and other health conditions

Mental disorders affect the rate of other conditions

- Mental disorders are associated with risk factors for chronic disease such as smoking, reduced activity, poor diet, obesity, and hypertension; however, these lifestyle factors have not yet been shown to mediate associations with morbidity and mortality
- Depression has various biological effects: on serotonin metabolism (alteration of cardiac function, platelet aggregation, and vasoconstriction); on cortisol metabolism (increased cortisol, leading to inflammation, excessive clotting, and the metabolic syndrome); on inflammatory processes (raised inflammatory markers, which also predict the development of cardiovascular disease); and on cell-mediated immunity (impairments in T-cell mediated functions, reduced natural-killer cell counts and cytotoxicity, with relevance to cancer, HIV progression and other infectious disease)
- Mental disorders and other health conditions could have common genetic or environmental risk factors

Some health conditions affect the risk of mental disorders

- Many chronic diseases create a psychological burden, which arises from factors such as the acute trauma of the diagnosis; the difficulty of living with the illness; the long-term threat of decline and shortened life expectancy; necessary lifestyle changes; complicated therapeutic regimens; aversive symptoms such as pain; and stigma, which can lead to guilt, loss of social support, or breakdown of key relationships
- Disability associated with chronic health conditions might mediate risk for depression and other common mental disorders

Some co-morbid mental disorders affect treatment and outcome for other health conditions

- Mental disorders can delay help-seeking, reduce the likelihood of detection and diagnosis, or do both
- The extent and the quality of general medical health care received by people with mental disorders might be poor. This evidence for this inequity is especially strong for those with psychoses, dementia, and substance-use disorders
- Mental disorders, cognitive impairment, and substance use and alcohol-use disorders adversely affect adherence to medication, to recommendations for behavioural modification, and to activities to prevent disease or promote health.

(Prince et al., 2007)

The list of potential interactions is long, and recurring interactions between chronic physical disease and mental ill health are common, with each feeding into and exacerbating the other (Dowrick, 2006). Nevertheless, there is variability in prevalence of depression rates across different chronic diseases (Penninx et al., 1996). Findings from this large body of research have been somewhat contradictory.

8.2.1 Variability in prevalence among chronic diseases

Some studies have found that there is little variability among chronic diseases in terms of psychological distress (Cassileth *et al.*, 1984). Others have shown that certain chronic diseases have elevated levels of psychological disturbance, including arthritis/rheumatism (Penninx et al., 1996; Wells, Golding, & Burnam, 1988), cancer (Wells et al., 1988), lung disease, neurological disorders (Ormel et al., 1997; Wells et al., 1988), heart disease (Ormel et al., 1997; Wells et al., 1988), lower back pain (Carroll, Cassidy, & Coté, 2000; Rush et al., 2000), stroke (Penninx et al., 1996), hearing impairment, vision impairment (Ormel et al., 1997), headache, and gastrointestinal problems (Carroll et al., 2000) and physical handicap. Finally, other studies have found that certain disorders are not associated with increased risk for psychological disturbance compared to other chronic conditions including hypertension (Patten, 1999; Wells et al., 1988), arthritis (Patten, 1999), heart disease (Patten, 1999; Penninx et al., 1996) and diabetes (Patten, 1999; Penninx et al., 1996; Wells et al., 1988). The fact that many of these conditions have been found to be both associated and not associated with increased psychological disturbance suggests that there is still much to learn about the relationship between depression and chronic disease.

Various reasons for the variation in psychological effect among different chronic diseases have been offered. It has been suggested that it is not the type of disease, but rather various other social and psychological factors that affects depression rates (Arpin, Fitch, Browne, & Corey, 1990). Some have suggested that the level of depression is directly associated to the severity of disability associated with the individual case of chronic disease (Ormel et al., 1997). Others have suggested that the degree of manageability of the disease is most important. For example, unlike cancer or arthritis, diabetes and cardiac diseases are relatively manageable by individual or medical efforts, and modifying behaviour by changing diet, medication and physical exercise may improve their health. (Penninx et al., 1996). Others have found that the meaning given to the illness is the most important factor influencing adjustment (Arpin et al., 1990). Arpin, Fitch et al. found that the meaning given to illness, followed by family function, and disability variables accounted for 57% in the variance in adjustment outcomes (Arpin et al., 1990).

8.2.2 Demographic variance

Among the general population, major depression is most common among younger individuals and among women (Hammen, 1997). Depression is also more common among women in the Aboriginal population (Thommasen et al., 2005; Wardman & Khan, 2004). Considering the young age of the Aboriginal population compared to the general population, and the relatively young age at onset of chronic disease among the Aboriginal population, the relationship between age, depression and chronic illness is of significance.

Cumulative epidemiological and clinically-based studies in the general literature have shown that children who have a chronic illness or disability are at a heightened risk for mental health problems (Cadman, Boyle, Szatmari, & Offord, 1987; Chernoff, Ireys, DeVet, & Kim, 2002; Haggerty, Roghmann, & Pless, 1975; Lavigne & Faier-Routman, 1992; Stein, Westbrook, &

Silver, 1998; Suris, Michaud, & Viner, 2004; Wolman, Resnick, Harris, & Blum, 1994; Yeo & Sawyer, 2005). In addition, adolescents with chronic illness report higher emotional distress and suicidal tendencies than their counterparts and that they rank below their peers on a number of psychological outcomes including emotional well-being, worries and concerns, and body image (Miauton, Narring, & Michaud, 2003; Rosina, Crisp, & Steinbeck, 2003; Suris et al., 2004; Wolman et al., 1994).

Results from a population-based study revealed that the estimated prevalence of a psychiatric diagnosis among children with reported chronic illness was 10%, almost twice the rate found in children without chronic illness (Hysing, Elgen, Gillberg, Lie, & Lundervold, 2007). This is consistent with previous studies, the Isle of Wight study being the classic example, which found psychiatric disorders rates of between 11.6% among children with chronic physical disorders not involving the brain to 34.4% among children with neuro-epileptic conditions, compared to 7% of healthy children (Rutter, Graham, & Yule, 1970). A population-based study in Ontario in the 1980s found that children with both chronic illness and associated disability were at greater than threefold risk for psychiatric disorders and considerable risk for social adjustment problems. Children with chronic medical conditions, but no disability were at considerable less risk: about a twofold increase in psychiatric disorders but little increased risk for social adjustment problems was observed (Cadman et al., 1987).

Among First Nations adolescents, youth with disabilities seem more prone to depression, which is defined as feeling sad, blue or depressed for more than two weeks in a row in the reference year (35.6% compared to 26.5% of youth without disabilities). Adolescents with disabilities are also more likely to have contemplated committing suicide at some point in their lives (32.4% compared with 20.1%) (First Nations Centre, 2005).

8.2.3 Chronic diseases and mental health – the relationship within specific chronic conditions

In order to add to the discussion of the general variance in the relationship between chronic disease and mental health, literature documenting the particular relationship between three of the chronic diseases discussed earlier in this section: (1) diabetes, (2) cardiovascular disease and (3) musculoskeletal conditions. Information will be drawn from the general literature, with specific reference to the Aboriginal research when it is available.

Diabetes

In the Canadian Aboriginal population, diabetes research may arguably be the most prolific area of chronic disease research. Despite this, little research has addressed the mental health aspect of this disease. Perhaps this is because diabetes is also considered to be one of the most challenging chronic conditions from a psychosocial perspective (Gonder-Frederick, Cox, & Clarke, 2002). This is because the diagnosis, treatment, and prevention is multifaceted and has a complex disease management structure:

There is no cure, diagnosis can occur at any stage of life, and, after diagnosis, daily treatment is required for the remainder of the lifespan, which may or may not successfully prevent the development of serious long-term complications, such as cardiovascular and kidney disease. The management regimen can be enormously

complex and relies almost solely on the intensive, daily efforts of patient and their families (Gonder-Frederisk et al., 2002).

As a result, the interrelation between diabetes and mental health needs to be carefully unpacked. Research has begun to do this over the last thirty years, the outcomes of this work will be reviewed to describe the obviously complex relationships between diabetes and depression.

The relationship between diabetes and depression can be thought to go both ways: depression may play a role in the development and worsening of diabetes (Sacco *et al.*, 2007) or depression may be the result of living with a chronic condition and the ensuing decrease in quality of life (Anderson, Freedland, Clouse, & Lustman, 2001; Gonder-Frederisk *et al.*, 2002; Knol *et al.*, 2006; Peyrot & Rubin, 1997). Prospective studies have shown that people who have depression have up to double the risk of getting type 2 diabetes independent of other associated risk factors (Eaton, Pratt, Armenian, Ford, & Gallo, 1996; Kawakami, Takatsuka, Shimizu, & Ishibashi, 1999; Knol *et al.*, 2006). Retrospective studies have also found a greater propensity for a history of depression among diabetics than non-diabetics (Gonder-Frederisk *et al.*, 2002; Lustman, Griffith, Freedland, Kissel, & Clouse, 1998; Nichols & Brown, 2000; Peyrot & Rubin, 1997). Exact estimates range (Anderson, Lustman, Clouse, De Groot, & Freedland, 2000; Bell *et al.*, 2005; de Groot & Lustman, 2001; Gavard, Lustman, & Clouse, 1993; Goldney, Phillips, Fisher, & Wilson, 2004; Nichols & Brown, 2000), but generally individuals with diabetes suffer depression at rates of two to three times that of the general population – affecting as many as one-third of individuals with type 1 or type 2 diabetes (Anderson *et al.*, 2001; Anderson *et al.*, 2000; Egede, 2005; Gonder-Frederisk *et al.*, 2002).

Depression in diabetes is associated with higher blood glucose levels, poor glycemic control, poorer lifestyle and medication adherence, decreased quality of life, substantially higher health care costs, increased risk for complications and increased mortality (Anderson *et al.*, 2001; Egede, 2005; Gavard *et al.*, 1993; Goldney *et al.*, 2004; Gonder-Frederisk *et al.*, 2002; Kawakami *et al.*, 1999; Keawe'aimoku Kaholokula, Haynes, Grandinetti, & Chang, 2006; Lustman *et al.*, 2000; McGill *et al.*, 1992; Peyrot & Rubin, 1997; Sacco *et al.*, 2007; Winokur, Maislin, Phillips, & Amsterdam, 1988). Depressed diabetic patients have been shown to have elevated blood sugar levels during a depressive episode and longer recovery times than non-depressed subjects (Winokur *et al.*, 1988). Often depression can be a stronger predictor of disease outcomes than physiological variables (Knol *et al.*, 2006; Rubin & Peyrot, 1999). Chronic anxiety has been shown to be related to glycosylated haemoglobin HbA_{1c}, a measure of diabetic control (Okada *et al.*, 1995). The same study found that improvements in anxiety might be useful in controlling glucose metabolism (Okada *et al.*, 1995).

In Canada, only one study was found that provided insight into the relationship between quality of life, diabetes and depression among Aboriginal Peoples. This study found that Aboriginals have lower quality of life than non-Aboriginals and that the average number of unhealthy days for mental health was higher among Aboriginal than for non-Aboriginal people (Thommasen, Berkowitz, Thommasen, & Michalos, 2005). Only a few studies conducted in the United States of America have examined the prevalence of depressive symptoms among Indigenous Peoples with diabetes (Bell *et al.*, 2005; Sahmoun, Markland, & Helgersen, 2007; Singh *et al.*, 2004; Tann, Yabiku, Okamoto, & Yanow, 2007). These studies have found inconsistent results. Some

studies showed rates of depressive symptoms several times more prevalent among Native Americans with diabetes than among other ethnicities (Tann et al., 2007), other Native American non-diabetics (Sahmoun et al., 2007; Singh et al., 2004), and greater, but not significantly so, than other ethnic minorities (Bell et al., 2005). Other studies found no association between race and measures of depression when other demographic and disease factors were controlled (Peyrot & Rubin, 1997). The dearth of studies on ethnic minorities, and Canadian Aboriginals in particular, means that little is known about the prevalence of depression among the Aboriginal diabetic population, regional variations, demographic and medical characteristics associated with higher depression, medical outcomes associated with depression, health care utilization, or effective and culturally-appropriate treatments (Bell et al., 2005; Rock, 2003).

The literature has documented a relationship between depression and diabetic complications (de Groot, Anderson, Freedland, Clouse, & Lustman, 2001): although the direction of the relationship is not clear. Diabetics who are depressed are at increased risk for diabetes-related complications and the greater the number or severity of diabetic complications the higher the level of depression (de Groot, Anderson, Freedland, Clouse, & Lustman, 2000; de Groot et al., 2001; Peyrot & Rubin, 1997). Depression may play a part in some complications (e.g. macrovascular disease) but not on other complications (e.g. nephropathy) (de Groot et al., 2001). Since certain types of complications are more prevalent among Aboriginals (e.g. renal complications (Hanley *et al.*, 2005) and that Aboriginal Peoples in Canada have higher rates of diabetes complications than among the general population (Hanley et al., 2005; Health Canada, 2000; Meatherall et al., 2005; Simpson et al., 2003), a better understanding of the relationship between depression and the complications most common for Aboriginal people, nephropathy for example, is needed.

Cardiovascular Disease

As noted earlier, cardiovascular disease (CVD) is a heterogeneous group of diseases of the heart and blood vessels, of which coronary heart disease or ischemic heart disease is the most common. While CVD has been found to be slightly higher in the First Nations population, rates among other Aboriginal groups are limited. When discussing CVD it is important to note its interrelation with diabetes and diabetes risk factors (Bruce et al., 2003; Simpson et al., 2003). This is important in the Aboriginal context, as diabetes and CVD have both been found to have high prevalence rates. Further, diabetics who suffer from depression are at an increased risk for cardiovascular disease: depression has been found to be an independent risk factor for the development of coronary heart disease among those with diabetes (Anderson et al., 2001). Egede (2005) found that those with for diabetes and depression were at significantly greater risk for death from all causes beyond that due to having either diabetes or depression alone, although diabetes remained a stronger predictor of coronary heart disease mortality than depression (Egede, 2005). The research on the interrelation between CVD and depression will be reviewed in greater detail below.

Cross-sectional and case-control studies have shown that rates of depression are higher among patients with coronary-artery disease than among the general population (Pratt et al., 1996). Up to 20% of patients with heart disease meet the criteria for major depression (Davidson et al., 2006), three times the community-based prevalence (Rozanski, Blumenthal, & Kaplan, 1999).

Between 15-45% of patients admitted to hospital following myocardial infarction (MI) are depressed and 40-50% report moderate to severe levels of anxiety (Bennett & Carroll, 1997; Glassman & Shapiro, 1998; Hippiisley-Cox et al., 1998).

Depression has been deemed to be an independent risk factor on par with other known medical prognostic factors as a risk factor for the development and the worsening of cardiovascular disease (Broadley, Korszun, Jones, & Frenneaux, 2002; Davidson et al., 2006; Frasure-Smith & Lesperance, 2005; Glassman & Shapiro, 1998; Hippiisley-Cox et al., 1998; Smith & Ruiz, 2002; Sullivan et al., 1999). A number of studies support the notion of a gradient between the magnitude of depression and future cardiac events, suggesting that risk for coronary artery disease associated with depression exists along a continuum, with the relative risk depending on the magnitude of depressive symptoms (Glassman & Shapiro, 1998; Rozanski et al., 1999).

Among patients with pre-existing cardiovascular disease, depression has consistently been associated with a worse outcome (Carver, 2007; Glassman & Shapiro, 1998). Estimates of the effects of depression on heart disease vary from study to study but range from a one-and-a-half-to seven-fold risk of fatal cardiac events (Broadley et al., 2002; Davidson et al., 2006; Frasure-Smith & Lesperance, 2000; Pratt et al., 1996). Depression is also associated with adverse medical outcomes such as poor compliance, increased health care utilization (Gilmer *et al.*, 2005), increased morbidity and mortality, and decreased quality of life (Davidson et al., 2006; Hippiisley-Cox et al., 1998; Lustman, Clouse, Griffith, Carney, & Freedland, 1997), even at low levels (Davidson et al., 2006). One study found an increased risk for cardiac mortality or MI among 72% of its participants reporting only two symptoms of depression, a level of depression insufficient to diagnose major or even minor depression (Horsten, Mittleman, Wamala, Schenck-Gustafsson, & Orth-Gomér, 2000). Among those who have suffered a heart attack higher levels of depression or anxiety is associated with increased mortality and morbidity, poor emotional recovery, lack of short term improvement, and longer latency to normal levels of activity (Bennett & Carroll, 1997; Gorkin, Follick, Wilkin, & Niaura, 1994; Pratt et al., 1996; Smith & Ruiz, 2002).

A study among Australia Aborigines found that stress and worry relating to the changing social situation within the community were frequently identified as a perceived cause of heart disease and as a complicating factor in managing it (Ong & Weeramanthri, 2002). The community saw heart disease as a symbol of contemporary social problems and of uncertain community direction (Ong & Weeramanthri, 2002). Citing Humphrey et al. 1998, Ong and Weeramanthri (2002) state that the stress and worry experienced by Indigenous people was often not recognized as such by non-Indigenous people, who see stress as being solely related to a modern lifestyle and overwork. As Skinner and Silverman-Peach (1989) describes, non-Indian health care providers often misperceive the stoic demeanour of Indian people (in the presence of non-Indians) as indicating the absence of stress (Skinner & Silverman-Peach, 1989).

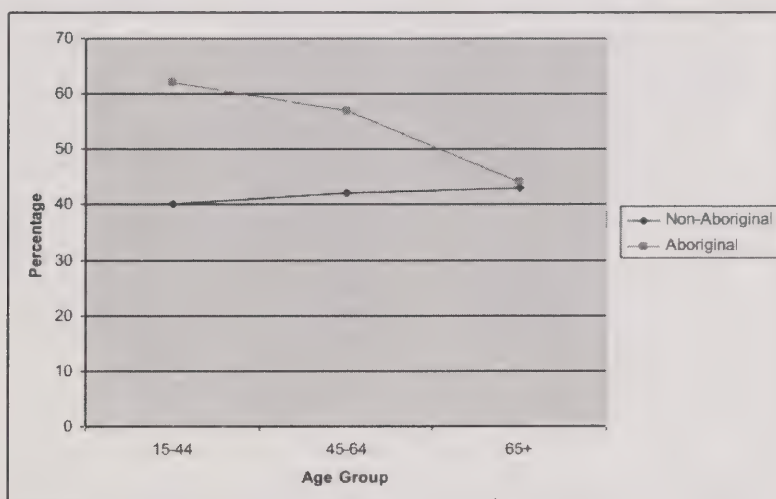
Musculoskeletal Diseases

As noted in the musculoskeletal burden section, arthritis is one of the most prevalent chronic health conditions in Canada and a major cause of morbidity, disability and health care utilization (Lagacé, Perruccio, DesMeules, & Badley, 2003). Much of the literature reports on the

prevalence of musculoskeletal conditions using the heading 'arthritis/rheumatism' to refer to this collection of painful joint disorders that range from those related to wear and tear of cartilage (osteoarthritis) to those associated with inflammation resulting from an immune disorder (rheumatoid arthritis). As such, it is often too difficult to separate these two conditions. While the relation between arthritis and osteoarthritis, and mental health will be referred to wherever possible information, statistics related to arthritis/rheumatism will also be used.

Rates of arthritis/rheumatism are 1.5 times higher among First Nations/Inuit than among the general Canadian population (Committee, 2004). As such, among Aboriginal adults, arthritis/rheumatism is the most commonly reported chronic condition (Statistics Canada, 2003) with an age standardized prevalence of 27% compared to 16% among the non-Aboriginal population (Committee, 2005; Lagacé et al., 2003). Since the prevalence of arthritis/rheumatism increases with age (Lagacé et al., 2003) the impact of arthritis/rheumatism on the Aboriginal population is expected to increase as the population continues to age (Burke, Zautra, Schultz, Reich, & Davis, 2002).

Figure 5. Proportion of individuals with arthritis who reported an HUI score indicative of disability, by age, Aboriginal people living off reserve and non-Aboriginal people, household population aged 15 years and over, Canada, 2000



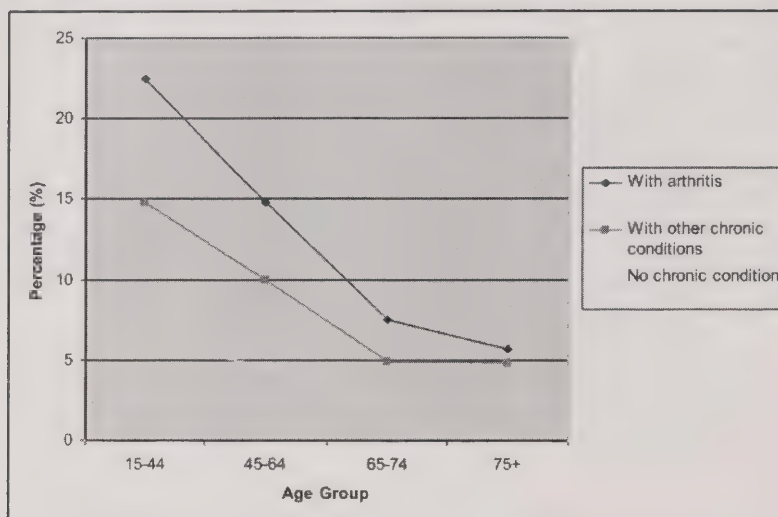
Source: (Lagacé et al., 2003)

Individuals with arthritis are more likely than people with other chronic conditions and no chronic conditions to suffer from activity limitations, increased disability, and moderate to severe pain (Lagacé et al., 2003; Verbrugge, Lepkowski, & Konkol, 1991). Verbrugge, Lepowski et al. (1991) found that comparing arthritic and non-arthritic people with the same total number of conditions, arthritis people had more physical limitations of all kinds (Verbrugge et al., 1991). They also found that when arthritis co-occurs with other chronic conditions, disability levels are augmented considerably. For example, for walking, Verbrugge, Lepowski et al. (1991) found that there was an over one hundred-fold increase in disability risk for people with both arthritis and other chronic conditions (odds ration 113.3) compared to an odds ration of 46.5 for the

people with other (non arthritis) chronic conditions (Verbrugge et al., 1991). Aboriginal people with arthritis also have been found to have higher rates of disability than non-Aboriginals with arthritis, as exemplified in Figure 2 (Lagacé et al., 2003).

As disability and pain are all associated with increased risk of depression, those with arthritis/rheumatism are at particular risk of depression (Barlow, Cullen, & Rowe, 1999). Individuals with arthritis/rheumatism experience more depression than the general population (Batlow, Cullen, & Rowe, 1999; Dickens, McGowan, Clark-Carter, & Creed, 2002; Hawley & Wolfe, 1993; Lagacé et al., 2003; Lin et al., 2003; Nagyoca, Stewart, Macejova, van Dijk, & van de Heuval, 2005; Nicassio, 2008; Treharne, Kitas, Lyons, & Booth, 2005) with depression rates between 17% and 42% being reported (Ang, Choi, Kroenke, & Wolfe, 2005; Evers, Kraaimaat, Geenen, & Bijlsma, 1997; Frank et al., 1988; Hawley & Wolfe, 1993; Rosemann et al., 2007) though not higher than those with other chronic conditions (Newman, 1997). Out of patients with moderately severe to severe symptoms of depression, only 19% discussed depression during their medical visits, and patients had to initiate the discussion with their provider each time (Sleath et al., 2008).

Figure 6. Proportion of individuals with case depression, by age, Canada, 2000



Source: (Lagacé et al., 2003)

The relationship between rheumatoid arthritis and depression has received more attention in the literature than the relationship between osteoarthritis and depression (Wolfe, 1999). Some studies have found that those with rheumatoid arthritis are more depressed than those with osteoarthritis (Dickens et al., 2002). Other studies however have not found depressive scores to be higher or more common among patients with rheumatoid arthritis (Hawley & Wolfe, 1993). Given that most First Nations individuals with arthritis suffer from osteoarthritis⁴ (First Nations

⁴ Surveys such as the FNIRHS do ask about "arthritis and rheumatism" but cannot distinguish the various diagnostic varieties. Most respondents who report having arthritis most likely suffer from osteoarthritis (Committee, 1999; First Nations and Inuit Regional Health Survey National Steering Committee, 1999)

and Inuit Regional Health Survey National Steering Committee, 1999) the majority of the research available is not on the condition most prevalent among Aboriginal Peoples. While rheumatoid arthritis is not the focus of our interest in chronic musculoskeletal conditions, the research that has been done in this area may be beneficial to better understanding the association between arthritis, osteoarthritis, and depression in Aboriginal communities.

Some authors, for example, have found that the time since onset of illness is important. Treharne et al. (2005) found that those with established rheumatoid arthritis were significantly less depressed than those recently diagnosed (Treharne et al., 2005). Others have found no difference in depression between recently diagnosed and chronic patients in terms of the distress they experience (Barlow et al., 1999; Barlow, Cullen, & Rowe, 2002; Evers et al., 1997). One study found that the strongest predictors of depression severity were perceived pain, few social contacts, physical limitation of the lower body and upper body, age, and body mass index (Rosemann et al., 2007). Another found that sex, pain and functional status, disease-related impact on daily life, and perceived social support were related to psychological distress among those recently diagnosed (Evers et al., 1997). Another study, on the other hand, did not find that pain was a significant predictor of depressive symptoms. Rather, beliefs about accepting one's illness and fatigue were more influential (Barlow et al., 1999).

Unlike other chronic illnesses there does not appear to be any suggestion of depression playing an etiological role in the onset of arthritis/rheumatism (Rosemann et al., 2007). Rather depression is seen as an additional burden that affects adjustment to the condition and ultimately the disease outcome (Burke et al., 2002). Co-morbid depression in individuals with arthritis has been shown to be an independent predictor of all-cause mortality with patients with persistent or recurrent depression twice as likely to die than patients with no depression (Ang et al., 2005).

A direct relationship between the physical markers of the extent or activity of the disease and depression have not been found (Newman, 1997). Research has shown that objective physiological measures of disease are not as robust a predictor of disability as psychological factors such as depression and pain (Botha-Scheepers *et al.*, 2006; Kee, 2003; Lin et al., 2003).

8.3 Common themes

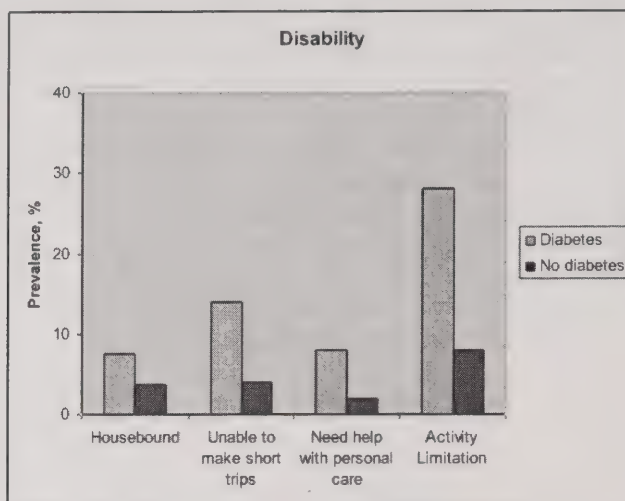
As is certainly evident from the above discussion, there are some themes common to chronic diseases that have a potential impact on one's mental health and can predispose individuals with chronic diseases to depression. The common themes of disability, quality of life, illness perception, self-perceptions, and self-control will be discussed briefly below.

8.3.1 Level of Disability

The relationship between level of disability and depression extends across many chronic conditions and has been explored within the context of the different conditions. The prevalence of chronic conditions has been associated with activity limitation among First Nations and Inuit populations in Canada, with 24% of people with hypertension, 28% of those with diabetes, 33% of those with arthritis, 36% of those with heart disease, and 38% of those with cancer reporting some degree of activity limitation (First Nations Centre, 2004). It has been found that those with increased disability suffer from poorer mental health (Barlow et al., 1999; Cadman et al., 1987;

Cassileth et al., 1984; Covington, 1991) and those with poor mental health have increased disability (Patten, 1999; Penninx, Leveille, Ferrucci, van Eijk, & Guralnik, 1999; Scott et al., 2008; Sullivan et al., 1999).

Figure 7. Prevalence of disability among First Nations people with diabetes, percentage rates



Source: First Nations and Inuit Regional Health Survey National Report 1999

A population-based study in Ontario in the 1980s found that children with both chronic illness and associated disability were at a greater than threefold risk for psychiatric disorders while children with only chronic medical conditions but no disability had only a twofold increase (Cadman et al., 1987). Penninx, Beekman et al. (1996) found that diseases involving more functional impairments such as stroke and arthritis had relatively stronger associations with psychological distress than other chronic diseases that had less functional limitations such as diabetes, cardiac disease and cancer. In contrast, some studies have found that among individuals living with chronic illness, decreases in physical functioning and advancement of chronic conditions were not associated with equal decreases in mental health, perhaps due to a process of psychological adaptation (Singer, Hopman, & MacKenzie, 1999). Overall, the research has shown that Aboriginals suffer greater disability than the general Canadian population (First Nations Centre, 2005). Among First Nations adults with diabetes, roughly one-quarter experience activity limitations due to the disease (First Nations Centre, 2005). Figure 4 presents data on the activity limitations of First Nations living with diabetes as reported in the 1997 FNIHRS.

Mental health disorders have also been shown to have negative effects on disability, at a rate equal to that of common chronic physical conditions. (Schonfeld *et al.*, 1997; Scott et al., 2008). One study found that depression in initially non-disabled older adults with chronic conditions significantly increased the risk for disability, especially for arthritis and angina (Penninx et al., 1999). In a study by Scott, Von Korff et al. (2008), individuals with mental disorder were more likely to be severely disabled than those with the physical conditions they investigated (diabetes, respiratory disease, headache, heart disease, arthritis, back or neck pain). They also found a synergistic effect between mental health and physical conditions: those with both mental and physical conditions were more likely to be severely disabled than those with either condition alone and had a greater likelihood than the sum of the odds of each condition individually (Scott et al., 2008). Directly related to disability is the impact of the association between chronic

disease and mental health and quality of life. This is discussed below.

8.3.2 Impact on Quality of Life

Health-related quality of life refers to the ways in which health, illness, and medical treatment influence an individual's perception of functioning and well-being. (Jacobson, de Groot, & Samson, 1997). Depression, chronic diseases, and quality of life are closely related although the direction of the relationship is not clear (Jacobson et al., 1997). Studies done with regards to people with diabetes found that diabetics with a diagnosis of depression have significantly lower quality of life compared with diabetics who are not depressed (Goldney et al., 2004; Gonder-Frederisk et al., 2002; Jacobson, De Groot, & Samson, 1994; Thommasen et al., 2005). The effect of depression on quality of life was found to be greater than the effect of diabetes on quality of life (Goldney et al., 2004). When just considering the impact of diabetes on quality of life, it was found that individuals with diabetes have considerably worse quality of life compared to the general population (Gonder-Frederisk et al., 2002; Jacobson et al., 1997; Mayou, Bryant, & Turner, 1990; Rubin & Peyrot, 1999; Steed, Cooke, & Newman, 2003).

Table 5. Self-determination indicators by feelings of depression or sadness

% Strongly agreeing that...	Depressed	
	Yes	No
I can solve the problems I have	32.4%	38.5%
No one pushes me around in life	33.8%	41.0%
I have control over things that happen to me	28.0%	31.1% (NS)
I can do just about anything I set my mind to	35.2%	43.2%
I often feel helpless in dealing with the problems of life	7.4%	4.1%
What happens to me in the future mostly depends on me	37.0%	37.6% (NS)
There's little I can do to change many of the important things in my life	10.6%	5.9%

Source: First Nations Regional Longitudinal Healthy Survey (RHS) 2002/03: Results for adults, youth and children living in First Nations Communities

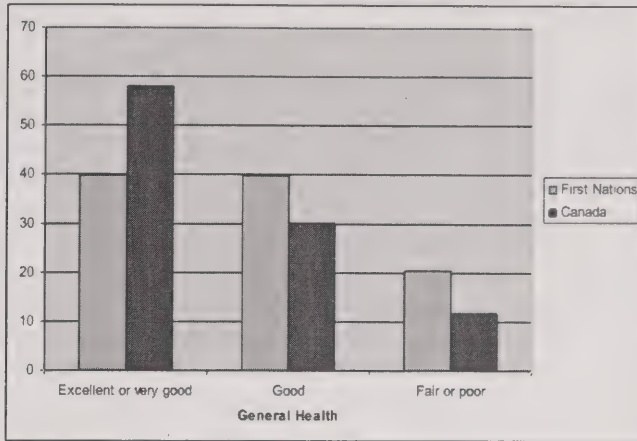
The reason for this is likely multifactorial. Diabetics tend to be overweight, engage in less physical activity and are more likely to have medical co-morbidities (Gonder-Frederisk et al., 2002; Jacobson et al., 1997; Rubin & Peyrot, 1999; Thommasen et al., 2005). Better quality of life is associated with low blood glucose levels and tight metabolic control (Jacobson et al., 1997; Rubin & Peyrot, 1999). In Canada, only one study was found that provided insight into the relationship between quality of life, diabetes and depression among Aboriginal Peoples. This study found that Aboriginals have lower quality of life than non-Aboriginals and that the average number of unhealthy days for mental health was higher among Aboriginal than for non-Aboriginal people (Thommasen et al., 2005). As the majority of information in this area has focused on diabetes, research on the impact of other chronic diseases and their association with mental health on quality of life will be important to engage with in the future.

8.3.3 Illness perceptions and self-perceived health status

Illness perceptions and illness acceptance influence depression in individuals living with chronic diseases (Stanton & Revenson, 2007). Illness perceptions are the beliefs that patients hold about their illness, its effects, why it has happened, how long it will last and whether it can be cured or controlled (Botha-Scheepers et al., 2006). Among those with arthritis/rheumatism, illness perceptions have been shown to have a strong impact on outcomes (Botha-Scheepers et al., 2006). For example, a patient who sees the illness as negative, uncontrollable, and chronic are more likely to adjust poorly to the illness, report greater disability, have lower life satisfaction and suffer from greater depression, anxiety, pain, and fatigue (Botha-Scheepers et al., 2006; Kee, 2003; Nagyoca et al., 2005; Treharne et al., 2005). Alternatively, a person who accepts their chronic disease is able to set up new reasonable frames or goals and be able to fulfill them (Nagyoca et al., 2005). Arpin, Fitch et al. (1990) found that the meaning given to illness was the largest contributor to the variance in adjustment outcomes observed among individuals with chronic illnesses, regardless of the type of illness or its severity (Arpin et al., 1990). They then suggested that since there is no relationship between the severity of disease and the meaning given to the illness, unfavourable attitudes towards illness should be used to identify subjects in need of psychosocial services (Arpin et al., 1990).

Research among American Indians with rheumatoid and osteoarthritis found that individuals expected to have decreased functional abilities and increasing pain and suffering (Kramer, Harker, & Wong, 2002). The same research found that negative thoughts, which have been associated with poor psychological outcomes and greater physical disability were generally absent (Kramer et al., 2002). McCubbin, Thompson et al (1993) found that Native American Indians defined the meaning of disability as part of a more general pattern of harmony disharmony, and viewed individuals with chronic conditions as a valued, functioning member of society rather than as some one that is different or stigmatized.

Self-perceived health status has also been found to be an important factor affecting depression among those with chronic disease. Among First Nations, self-perceived health has been related to suicide, the most dramatic indicators of distress. Suicidal thoughts were found to be more common among those with fair or poor rated health (38.4%) than among those with excellent self-reported health (28.9%) (First Nations Centre, 2005).

Figure 8. General health of First Nations and other adults in Canada

Source: First Nations Regional Longitudinal Healthy Survey (RHS) 2002/03: Results for adults, youth and children living in First Nations Communities

Optimism is associated with less anxiety, depression and more life satisfaction among individuals suffering from rheumatoid arthritis. There is also evidence that people with a sense of high self-esteem, control and optimism adjust more successfully to chronic illness (Helgeson & Reynolds, 2002). Optimism has been associated with lower pain at initial onset of arthritis and interestingly higher pain for those with established disease, reflecting possibly unmet expectations of improvement or betterment of their condition (Treharne et al., 2005).

8.3.4 Body Image and Self-esteem

In a similar way to one's perception of disease, self-esteem has been found to be associated with both physical and psychological health. While no research directly examines the relationship between self-esteem, depression and chronic disease among Aboriginals, studies in other populations and with regards to one or more of these areas can be used to begin to unpack the relationship. For example, low self-esteem has been found to double the risk for later depression (Nagyoca et al., 2005). Among individuals with rheumatoid arthritis, higher levels of self-esteem, along with better adjustment to the illness were associated with less psychological distress (Nagyoca et al., 2005). Body image and self-esteem have been particularly linked to the psychological health among those with chronic illnesses among adolescents. A study by Wolman et al. (1994) found that body image was the most important predictor of emotional well-being for students with chronic conditions, suggesting that a strong sense of self (i.e. body image) as well as family cohesion and support were more important than having a disability on positive emotional development. Adolescents in British Columbia with chronic illnesses or disabilities are more likely than those without to have low self-esteem (17% vs. 5% respectively) (The McCreary Centre Society, 1994). Among First Nations youth with disabilities, 78.2% are somewhat less likely to agree or strongly agree with the statement "I like the way I am" compared to 85.6% among youth without disabilities. The difference is most pronounced among males, among whom 79.6% with disabilities agree or strongly agree with the statement compared

to 90.4% of their counterparts without disabilities (First Nations Centre, 2005). In addition to a sense of comfort and pride in one's body and personal ability, sense of control over one's lives is also interconnected with chronic diseases and mental health.

8.3.5 *Mastery*

A sense of mastery refers to the extent to which people see themselves as in control of their lives (De Marco, 2000). Low perceived mastery includes feelings of helplessness and is associated with worse health and psychological outcomes (Daniel, O'Dea, Rowley, McDermott, & Kelly, 1999; Gonder-Frederisk et al., 2002; Sunday, Eyles, & Upshur, 2001). Lower feelings of mastery may be more frequent among those with chronic illnesses because of the progressive physical deterioration and unpredictable symptom flare-ups common in many chronic diseases (Helgeson & Reynolds, 2002), and the greater likelihood of individuals with chronic illness or physical disability to be confronted with problems that are not amenable to problem solving (Penninx et al., 1996). A high sense of mastery has been linked to improved physical and psychological health status among individuals with arthritis (Barlow et al., 2002; Burke et al., 2002) and among Aboriginal Canadians, good mastery skills have been associated with healthy blood lipid levels (Daniel, Rowley, Herbert, O'Dea, & Green, 2001) and low fasting glucose levels (Daniel et al., 1995). Similarly, American research has found an inverse relationship between arthritis pain among American Indians and a sense of mastery (Kramer et al., 2002). Another study found that individuals with arthritis and very high self-efficacy had higher pain thresholds and higher pain tolerance, while those with low self-efficacy had greater physical impairment, more pain, more fatigue, more depression and anxiety and less acceptance of their condition (Barlow et al., 2002). One study among women with physical disabilities found that women equipped with high levels of personal resources (sense of mastery, self-esteem, or hardiness) had significantly better long-term psychosocial adaptation: perhaps due to their ability to better cope with the daily hardships and familial role difficulties of their illness and to use their limited concrete resources more efficiently (Dangoor & Florian, 1994).

The 2002/03 Regional Health Survey (RHS) asked questions closely relating to mastery, and the results (see Table 3 below) differ among those who were and were not depressed (First Nations Centre, 2005). Among Canadian adult First Nations who were depressed, only 28% strongly believed that they had control over things that happened to them, 7.4% felt helpless in dealing with problems of life and 10.6% strongly believed that there was little they could do to change many of the important things in their lives (First Nations Centre, 2005). The RHS found a similar pattern among youth with disability (First Nations Centre, 2005).

Unfortunately, feelings of powerlessness and a low degree of controllability over the elements that affect their lives are common in many Aboriginal communities, largely as a result of the ongoing impacts of colonization (Boston et al., 1997; Grams et al., 1996). This powerlessness has long been recognized as a major factor shaping Aboriginal health (Tsey & Every, 2000).

8.4 Co-morbidity

8.4.1 *Cancer and Diabetes*

Diabetes appears to increase the risk of developing cancer in general due to the fact that changes in the body cells affected by diabetes may facilitate the growth of cancer cells. In particular,

cancers of the liver, esophagus, colon, pancreas and other cancers related to obesity (Marrett, 2003). Factors that are associated with increased rates of diabetes include being overweight or obese, abdominal obesity, physical inactivity, family history of diabetes, previous diagnosis of gestational diabetes, high saturated fat intake, high blood pressure, high cholesterol, impaired glucose tolerance, and being of Aboriginal, African, Hispanic or Asian ancestry (Health Canada, 2000). As can be seen from the list of risk factors for diabetes, many of them are common risk factors for cancer as well, such as a fat diet, inactivity and obesity. The prevalence rate of diabetes in the First Nations population in Canada is very high: 19.7% of First Nations vs. only about 4.9-5.8% of the average Canadian population. According to Regional Health Survey 2002-03, most First Nations (78.2%) have been diagnosed with type 2 diabetes, 9.9% with type 1 diabetes and 9.8% have been told they are in a pre-diabetes state (2002/2003). Diabetes and glucose intolerance are the most common risk factors for CVD in the Aboriginal population (Harris et al., 2002), which is why the connection between these two chronic conditions and their risk factor interactions are so important to understand. Therefore, any risk factor for diabetes is an indirect risk factor for CVD.

8.4.2 Diabetes and CVD

Diabetes is a risk factor for the development of cardiovascular disease. Approximately 70% of deaths in adults with diabetes is from cardiovascular disease (Daniel *et al.*, 2001; Gilmer *et al.*, 2005). The Strong Heart Study conducted among Indian communities in Arizona, Oklahoma, and South and North Dakota found that diabetes was very strongly associated with coronary heart disease in American Indians (Howard *et al.*, 1995). Hypertension is a risk factor for the development of cardiovascular disease (Johnston, 1997) and is somewhat more prevalent among First Nations adults overall when comparing with the general population (20.4% compared with 16.4%) (First Nations Centre, 2005). Other reports have estimated the prevalence of hypertension and heart problems among First Nations on reserve to be approximately three times the rate among the general Canadian population (Health Canada, 2000). Blood lipid levels are also associated with the risk of developing heart disease, and interestingly, healthy blood lipid levels have been associated with good mastery skills and low depression among Aboriginal Canadians (Daniel *et al.*, 2001). Among First Nations, 50% of the respondents with diabetes reported having hypertension, and 26% reported having heart disease, prevalence rates that were 3.3 and 3.9 times those among the respondents without diabetes, respectively (Young *et al.*, 2000). Other studies have found that 43% of First Nations with diabetes had hypertension, compared to just 10% of those without diabetes (Health Canada, 2000).

8.4.3 Osteoporosis and Chronic Diseases

A recent Manitoba study has found the following associations between osteoporotic fractures and chronic diseases (Leslie, 2006):

Diabetes diagnosis was found to be weakly associated with osteoporotic fractures after controlling for all variables;

Ethnicity was estimated to be strongly associated with higher rates of osteoporotic fractures;

Greater number of ambulatory diseases;

A substance abuse problem correlated with higher fracture risk at all sites.

8.4.4 Health Imbalance and Co-morbidity

The affect that mental illness can have on other dimensions of an individual's health will be discussed at the end of this section.

Given the debilitating effects that SMI can have, it should come as no surprise that individuals living with SMI can and often do experience additional health problems. For Indigenous Peoples who understand health as a balance between physical, mental, emotional, and spiritual health ([FNIGC], 2005; Canada, 2006; Smye & Mussell, 2001), imbalance in one dimension of health can cause imbalance in another. For instance, mental illness may impair the ability of an individual to engage in health-promoting behaviors that reduce the risk of physical illness (Lando, Williams, Williams, & Sturgis, 2006). Furthermore, poor mental health may impair the treatment of and recovery from existing chronic illnesses (Lando et al., 2006). Conversely, living with chronic physical illnesses, such as diabetes or cancer, can negatively influence the mental health of the individual (Lando et al., 2006). Emotional health may also be impaired by SMI; identifying one's self as mentally ill can lead to feelings of alienation and despair (Lefley, 1990). The link between mental and spiritual health may be less clear, however, at least some Indigenous individuals have recovered from mental illness by embracing and promoting spiritual health (Storck et al., 2000).

There is some evidence of the relationship between mental and physical health in the research addressing mental health of Indigenous Peoples. A recent study found cardiovascular disease (CVD) to be twice as prevalent among American Indian participants with a lifetime diagnosis of major depression than those without (Sawchuk et al., 2005). In the same study, CVD was more than twice as prevalent among participants with PTSD than those without, and established risk factors for CVD also occurred more frequently among participants with PTSD (Sawchuk et al., 2005). Other studies have linked substance abuse disorders (particularly injection drug use) to escalating rates of communicable diseases, such as HIV and hepatitis C, in Indigenous populations (Callaghan, Cull, Vettese, & Taylor, 2006; Spittal et al., 2007).

Substance use disorders have also been linked to other mental illnesses. Individuals suffering from SMIs are at heightened risk of substance abuse, possibly because of the individual's desire to 'self-medicate' undesirable psychological symptoms or to 'numb' painful feelings (Phoenix Kasten, 1999). As mentioned in the previous section on addiction, some Indigenous individuals have identified their substance abuse as an attempt to numb the pain caused by physical and sexual abuse, low self-esteem, loss of culture and identity, and family history of substance abuse (Wardman & Quantz, 2005). Thus, social burdens of families and communities can influence the mental well-being of an individual. In turn, behaviours of mentally ill individuals affect families and communities (Warry, 1998). The following section will discuss how family caregivers are affected by SMI and how social burdens of violence, substance abuse, incarceration and suicide affect the mental health of entire communities.

The large burden of chronic disease in Aboriginal populations, demonstrated by the previous "burden of disease" sections, highlights the need to understand risk factors for chronic diseases in Aboriginal populations. For, it is with such understanding of common risk factors that strategies to improve Aboriginal health and well-being can be developed.

A LIFE COURSE APPROACH: CHRONIC DISEASE RISK FACTORS IN ABORIGINAL POPULATIONS IN CANADA

1. Introduction: Taking a Life course Approach

In order to stem the rise of chronic diseases in developed countries throughout the twentieth century, and particularly in the post-war period, epidemiologists, health care professionals, and policy makers targeted adult risk factors (Kuh & Ben-Shlomo, 2004). Thus, targeting adult behaviour and lifestyle factors, such as obesity, smoking, and high cholesterol became the prevailing model for the prevention and intervention of chronic disease (Kuh & Ben-Shlomo, 2004). In the developed world, this approach and its programs have been very successful in alleviating problems associated with chronic diseases: results from the 40-year Framingham heart study indicate that in the United States, more than one-half of the decline in coronary heart disease mortality observed in women and one-third to one-half of the decline observed in men can be attributed to changes in adult risk factors (Sytkowski et al., 1996). Unfortunately, the overall improvement in adult risk factors and chronic disease is limited to certain populations: while rates of some chronic disease have declined in Western populations, chronic diseases are a growing cause of mortality and morbidity among vulnerable populations, like Canada's Aboriginal people (Smeja & Brassard, 2000).

Another problem with the adult risk factor approach is that, while adults are being targeted to change their lifestyle habits, the next generation will grow up in the same conditions that have fostered the development and onset of chronic disease in their parents. When these conditions are grounded in poor socioeconomic status, the disease risk is increased and the applications of an adult lifestyle approach to chronic disease is ineffective. Social disparities and inequities in health documented in Aboriginal communities across the country suggest that an adult risk factors approach alone is not enough. Results from recent Aboriginal studies reinforce a "determinants of health framework," which indicates that broader social-welfare provisions must be considered in the fight to reduce disparities in health (Newbold, 1998).

In the last 20 years, life course epidemiology has emerged as an alternative approach to the prevailing adult risk model described above (Kuh, Ben-Shlomo, Lynch, Hallqvist, & Power, 2003). Life course epidemiology has been defined as the study of long-term effects of physical or social exposures during gestation, childhood, adolescence, young adulthood, and adult life on one's developmental health and later disease risk (Kuh et al., 2003). Life course epidemiology offers a way to conceptualize how underlying biological and socio-environmental determinants of health, experienced at different life course stages, can differentially influence the development of chronic diseases (Moore & Davies, 2005). The benefit of this perspective is that it expands the conventional adult lifestyle models of disease risk by recognizing that psychosocial, as well as physiological factors occurring throughout an individual's life can affect a diverse range of outcomes, from general well-being to physical functioning and the development of chronic disease (Ben-Shlomo & Kuh, 2002, 1996; Darnton-Hill, Nishida, & James, 2004). A major strength of this approach is that it also shows how risks occurring throughout life can be identified, corrected, and/or modified over the long time frame it takes for chronic diseases to develop (Lynch & Smith, 2005). In a parallel manner, "a life course perspective allows one to see health differences among populations, social classes, etc. as resulting from an accumulation

of material disadvantages [and] that reflect widely differing economic and social life circumstances” (Darnton-Hill et al., 2004). Only after thinking of disease as an aspect of an individual’s life course can “the prevention and control of chronic diseases...be intimately integrated into normal daily life” (Darnton-Hill et al., 2004), and sustained to benefit the health of communities. Thus, strategies that address risk factors must continually account for “the underlying economic, gender, political, behavioural and environmental factors that foster these disease risks” (Darnton-Hill et al., 2004) within all age groups and across generations.

What the life course approach also adds to the adult risk factor model is an understanding of and attention to timing and the duration of exposures to risks (Ben-Shlomo & Kuh, 2002). There are a number of models that have been used to account for the importance of timing in disease development and used as a basis for underlying theoretical frameworks for life course studies. The critical period model assumes that exposure at a certain period, usually early in life, has a permanent effect that remains relatively stable throughout an individual’s life. This model can be extended by considering the interaction of these early exposures with exposures later in life. Another possible model is the accumulation of risks model that posits the development of disease as a result of cumulative exposure and damage over the life course to some threshold. Finally, there is a pathway model that suggests that exposure increases the likelihood of further exposure, which can eventually result in the development of a disease. While the exposure time, magnitude, and impact is different for each of these models, they all speak to the importance of engaging with the interconnection between time and disease risk in order to chart a better understanding of the etiology of chronic diseases. In addition to the benefit of life course for the organization and investigation methods of research, a life course approach provides an effective tool for policy makers. This is because, as the World Health Organization (WHO) notes, a life course approach can help identify the most effective and potentially successful policies and prevention methods for chronic diseases (WHO, 2005).

1.1 The Life Course Perspective and Aboriginal Health

The burden of chronic diseases in Aboriginal populations, is a serious public health concern. And as the morbidity and mortality rates related to chronic diseases continue to show signs of growth in this population (Smeja & Brassard, 2000), a new approach to studying disease trends and facilitating positive interventions is needed. As described above, the life course perspective provides an appropriate theoretical model to do this. Further still, the life course approach is complementary to Aboriginal perspectives on health. For one, a life course perspective provides researchers with the tools to integrate scientific, cultural, and sociological knowledge in a meaningful way; this fusion is necessary to satisfy both the scientific and cultural requirements of Aboriginal health research.

Secondly, life course research understands health in an holistic way (Lynch & Smith, 2005), which complements Aboriginal conceptions of health and well-being that encompass the physical, mental, emotional, and spiritual domains (Bartlett, 1998). This is exemplified by a quote from the 2002/03 First Nations and Inuit Regional Health Survey: “The medicine wheel life cycle connects the experiences and wellness of infants to the experiences and wellness of children, youth, young adults, parents, grandparents, and elders, again from an individual, family, community, and First Nations perspective” (First Nations Centre, 2005).

The crisis in Aboriginal Peoples' health today is complicated by issues that are deeply rooted in social disparities (Adelson, 2005), which is why there is concern that no amount of risk assessment or health recommendations will reduce the burden of disease without a parallel understanding of the importance of social change. Life course epidemiology offers a conceptual framework to integrate social and biological risk factors (Kuh et al., 2003): it allows the researcher and the community to map out the dominant risk patterns in their region and target their eradication before an accumulation of those risks becomes a problem. Since research that is "by and for" Aboriginal peoples and reflects Aboriginal perspectives is the most likely to improve the health of Aboriginal Canadians (O'Neil, Reading, Bartlett, TK, & J, 1999), life course's recognition of social and cultural values is also promising. As different Aboriginal populations gradually acquire the resources necessary for their empowerment, the applications of life course epidemiology could have the potential to be used in novel prevention-based policy recommendations.

1.2 Applying the life course approach

By studying an individual's development and exposures to risks throughout the life course, in terms of biological conditions and socioeconomic factors, chronic disease patterns can be better understood. Thus, the risk factors noted in the literature will be discussed in the particular life stage that they have a profound impact or at which they place an individual at the greatest risk for developing chronic diseases. This section will begin, however, with a discussion of the community-level or broad reaching risk factors that influence health and well-being across the life course. These cross-cutting risk factors are discussed first to help set the stage and highlight the underlining factors influencing the health and well-being of the Aboriginal population. Following this, this section will begin to look at the specific life stages. Naturally, this will begin with a discussion of prenatal risk factors. It will follow with in-depth discussions of natal, early childhood, childhood and adolescent, and adulthood risk factors. This is a natural and logical ordering that follows the life trajectory and temporal course of risk exposure and disease development. While this separation of the different life stages is important, it is also important to remember that many risk factors are present at multiple life stages. To avoid duplication, the importance of the timing of the exposure and the impact of risk factors on long-term health and development will be given attention.

A broad "determinants of health" perspective will also ground the discussion of the risk factors. That is, biological, social, economic, environmental, and political factors that affect one's health, and the health of communities, populations, and generations will all be included. This will enable a broad discussion of the complex risk factor environment for Aboriginal populations in Canada and around the world.

2. Community Risk Factors

"Community" risk factors are defined and discussed here as those that have impact health at multiple life stages, beyond an individual's life span, across a generation, and between generations. These multi-level factors are an important addition to the traditional risk factor model: thinking of risk factors as they act across and within generations is important because it encourages the consideration of collective health issues and the interconnections that exist between health and society. This will build on the discussions of the previous chapter, the

Aboriginal health research environment, which demonstrated how the efforts of the Canadian government to oppress the cultures, traditions, and community structures of Aboriginal populations has caused collective trauma and grief and has culminated in health problems in many Aboriginal communities ([FNIGC], 2005; Kirmayer, Brass, & Tait, 2000). In addition to the social, political, cultural, and academic history of Aboriginal health, this section will examine the community risk factors associated with socioeconomic status and geography. This focus is important because it will enable a rich discussion of the social determinants of health that act on communities and collectives and impact the health and well-being of such communities. This is particularly important to do with regards to the prevalence of chronic diseases, where social, economic, and environmental issues have been shown to have a profound effect on disease risk and mortality (NSW Health, 2006).

2.1 Socioeconomic Risk Factors

The ill health of Aboriginal Peoples has been linked to “the corrosive effects of poverty and economic marginalization” (Kirmayer et al., 2000), but these social determinants of health have themselves been described as both direct and indirect consequences of historic policies of colonization ([FNIGC], 2005; King, 2006). As such, the risks associated with colonization are interrelated and connected to the risks posed by socio-economic disadvantage (Beauchamp et al., 2004; Canada, 2003; Carson, Dunbar, Chenhall, & Bailie, 2007; Reading, Kmetz, & Gideon, 2007). Unfortunately, Indigenous Peoples worldwide are disproportionately burdened with disease risk from such social determinants as poverty, low household incomes, and lack of adequate (or no) housing ([FNIGC], 2005; Adelson, 2005; Beauchamp et al., 2004; Canada, 2006; Canada, 2003). Since “social inequality, whether measured at the population or individual level, is the single leading condition for poor health” (Geyorfi-Dyke, 2008), such social disadvantages highlight the risks placed on the health and well-being of Aboriginal Peoples in Canada. The potential impact of socioeconomic factors is even more obvious when one considers the burden placed on the biological development of individuals as these disadvantages accumulate across the life-course and across generations (Adelson, 2005; Beauchamp et al., 2004; Carson et al., 2007; Marmot & Wilkinson, 1999; Warray, 1998). It is from this perspective that the specific influence of poverty and socioeconomic status, as well as housing, on chronic disease development is discussed below.

2.1.1 Low Socioeconomic Status and Poverty

While child poverty is briefly discussed in the “early childhood risk factors” section, the impacts of poverty and poor socioeconomic status on chronic diseases are included here to emphasize the intergenerational and cyclical nature of poverty: child poverty is family poverty, is community poverty, is generational poverty. That is, poverty never affects just one individual, at one time, but is an issue that transcends age, time, and space.

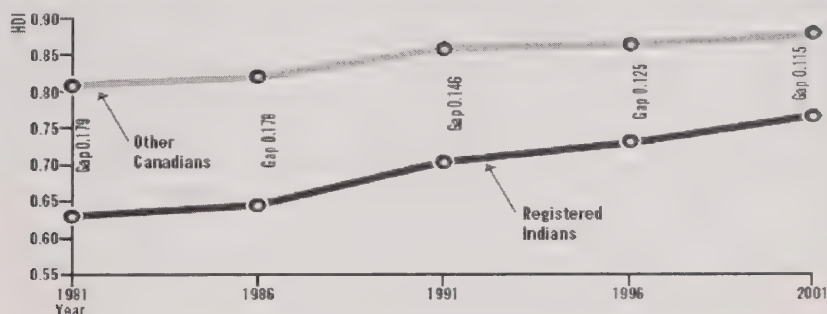
Defining and Describing Poverty for Aboriginal Peoples in Canada

While poverty can (and has) been described and defined in a number of different ways, it is often classified according to its extremity. As such, it is often labelled as: extreme, moderate, and relative poverty. Extreme poverty is when households (or individuals) cannot meet their basic needs for survival. Moderate poverty is when basic needs are barely met. And, finally, relative poverty is when the household income is less than the national average income (World Health

Organization, 2008). Thus, relative poverty is often equated with the terms “low income” and “poor/low socioeconomic status.” In Canada, relative poverty, or low income, is measured using the low-income cut-off (LICO) level developed by Statistics Canada (Ross, Shillington, & Lochhead, 1994; Statistics Canada, 1999). Despite the presence of varied experiences, measures, and approaches, it is clear that all types of poverty adversely affect one’s health. As such, this section will discuss the general connection between poverty and chronic diseases. First, however, the prevalence of poverty among Canada’s Aboriginal population will be reviewed.

To measure and compare the quality of life between different countries or populations, the United Nations developed the Human Development Index (HDI). This index has been applied in Canada in an effort to compare the quality of life and well-being of Aboriginal and non-Aboriginal people in Canada (INAC, 2004). Canada has been consistently ranked according to the HDI as one of the top five countries in the world. When the HDI rank is controlled for Aboriginal ancestry, however, Canada’s Aboriginal population ranks at a shockingly low 78th place (Blackstock, 2005). This highlights the often-sighted analogy that Aboriginal Peoples in Canada are living in Third World conditions within a First World country (O’Neill, 2007). This is demonstrated by the gap between the red and blue lines in figure 1 below. The figure also demonstrates that: (1) the HDI score for both Registered Indians and other Canadians has increased from 1981 to 2001; (2) the gap in HDI scores has reduced (from 0.179 in 1981 to 0.115 in 2001), and (3) a large discrepancy between the health of Registered Indians and other Canadians clearly and profoundly remains.

Figure 1. The Human Development Index for Registered Indians and Other Canadians, 1981-2001 (INAC, 2004).



Source (INAC, 2004)

In addition to the HDI, income statistics and poverty rates exemplify the poor socioeconomic status of many Aboriginal Peoples in Canada. For example, “47.2% of the Ontario Aboriginal population receives less than \$10,000 per year” (Ontario Federation of Indian Friendship Centres, 2004). Canada-wide statistics also show that Aboriginal people are economically disadvantaged: 73.4% of Aboriginals earn < \$20,000 per year, and the average income is \$ 15,699 versus \$25,414 in the rest of Canada (Sin et al., 2002). Information collected in urban settings demonstrates that this subset of the Aboriginal population is significantly disadvantaged compared to their non-Aboriginal counterparts. For example, a study done in 2000 reported that

Aboriginal Peoples living in urban settings are twice as likely to live in poverty than non-Aboriginal people (Lee, 2000). Further, while accounting for only 1.5% of the urban population, Aboriginal Peoples account for 3.4% of the poor population (Lee, 2000).

Poverty and Health

As has been demonstrated elsewhere and will be discussed in the life stage discussions, traditional adult risk factors, such as smoking, high blood pressure, obesity, and poor diet, are common and concerning risk factors for the development of chronic diseases. However, such risk factors only explain a fraction of the incidence and prevalence of chronic disease and the mortality from such diseases in Aboriginal populations. For instance, research has continually shown that socioeconomic status (SES) can have a profound impact on the prevalence and mortality of disease (Marmot, 1987; Smith, Hart, Blane, Gillis, & Hawthorne, 1997; Syme & Browne, 2002; Syme, 2004; van Rossum, 2000): there exists “abundant data showing a link between poverty and ill health” (Marmot & Wilkinson, 1999). For instance, it has been noted that “the higher the socio-economic level of the household the lower the mortality rate” (Marmot, 2005). Research has found that traditional adult risk factors can only account for approximately 25-35% of the mortality associated with this “social gradient” (Marmot, 2005; Syme, 1989). While all aspects of this association have yet to be determined, research documenting the relationship between poverty and chronic disease prevalence and mortality will be discussed below.

Poverty increases an individual's, a family's, and a community's risk of developing chronic diseases, developing complications, and dying (World Health Organization, 2008). This is because material deprivation, unhealthy living conditions (e.g. poor housing, inadequate food supply), and poor access to health care services predispose people with low socioeconomic status to the development of chronic diseases and the uptake of risk behaviours throughout the life course (NSW Health, 2006). For instance, the World Health Organization (WHO) notes that “the poor and people with less education are more likely to use tobacco products and to consume energy-dense and high-fat food, be physically inactive, and be overweight or obese” (World Health Organization, 2008). Psychosocial stress is also considered to be a major contributor to the ill health of those living in poverty. Notable researchers, such as Marmot and Syme, discuss such stress as the loss of one's control over their destiny and, therefore, their ability to deal with the forces that affect their day-to-day lives is a key component of the link between socioeconomic status and health (Marmot, 2005; Marmot, 1998; Syme, 1998; Syme, 1989; Syme, 2004). This theory has been supported by research that has found that “control of destiny” is lower in the lower status groups (Marmot, 2005). Neuroendocrinological studies have also shown that lack of control over life circumstances creates a load of stress on the body, which may eventually result in the development of a variety of diseases and conditions, especially insulin dependent diabetes, cardiovascular diseases (McEwan, 1998; McEwen, 2006), alcoholism, and suicide (Syme, 1998). In addition to the imposition of stress and loss of control over one's future, stress related to finances, lack of access to healthy food (or food at all), lack of access to basic health care, poor living conditions, and inability to provide basic needs demonstrate the correlation between poor socioeconomic status and health (Behrman, 1995). While there is reason to be encouraged by the fact that the socioeconomic status of many Aboriginal Peoples has increased in recent years, the gap between Aboriginal and non-

Aboriginal people in Canada remains (see figure 1 above). The same is true for other Indigenous populations around the world: Indigenous populations in developed countries are “a socially excluded minority within their countries” (Marmot, 2005) and “over-represented in lower SES [socioeconomic status] strata” (Valery, 2006). The direct impact of the overrepresentation of Aboriginal Peoples in the lower SES levels on mental health, cancer, and respiratory disease, as examples of specific chronic disease impacts, is presented below.

Socioeconomic disparities and, particularly, their relationship to a loss of control of destiny are a major risk factor for mental health problems (Canada, 2006; Warry, 1998). As Warry (1998) explains, problems of alcohol abuse and family violence among Aboriginal Peoples are deeply rooted in a perceived lack of control over life. Syme (2004) suggested that a lack of “control of destiny” contributes to community-level health problems and interferes with the desire among Aboriginal Peoples to assume responsibility for their health and well-being (Warry, 1998). For instance, some severely mentally ill individuals have identified poverty to have a debilitating impact on their self-esteem, social networking, leisure activities, and abilities to meet their basic needs, visit their family members, and form intimate relationships (Wilton, 2004). The debilitation from poverty is often thought to be more difficult to deal with than the diagnosis or ongoing treatment of the disease itself. And, issues related to poverty tend to exacerbate the intensity, persistence, and effects of the disease (Lee, 2000).

The relationship between socio-economic status and cancer risk is very complex. This is because current research reports that having a higher socioeconomic status can predispose people to some types of cancer (i.e. lung, breast, colorectal), while having a lower socioeconomic status can place people at risk for other types of cancer (i.e. stomach, liver, and cervical) (Brown & Lipscomb, 2006). Comparisons between developed and developing countries, which has led to these conclusions, are translatable to the study of Aboriginal cancer risk in Canada, as Aboriginal people have been likened to developing societies that live within a developed country (Epstein, 1982). And, as the prevalence of cancer in Aboriginal populations in Canada shows, the “third world cancers” are generally more common in Aboriginal Peoples than are the “Western cancers.” This suggests that targeting the socioeconomic status, as a risk factor will help alleviate cancer risk among Aboriginal Peoples. Attention to the role that income has on the burden of cancer in Aboriginal populations is also important in terms of cancer survival rates: low socioeconomic status has been shown to lead to decreased cancer survival rates as well as increased cancer fatality rates (Marrett, 2003).

Socioeconomic status has also been shown to impact the prevalence of diabetes. A 2003 study found substantial clustering of diabetes in areas of Winnipeg with low socioeconomic status, poor environmental quality, poor lifestyles and a high concentration Aboriginal people (Green, Hoppa, Young, & Blanchard, 2003). The study found that education and income were stronger predictors of diabetes than Aboriginal status, suggesting that socioeconomic status, rather than genetic factors were responsible for the high prevalence of diabetes (Green et al., 2003). Despite studies that demonstrate potential correlations between poverty and health, it is important to remember that poverty alone does not determine the health of an individual or population. Thus, the complete nature of the relationship between poverty and illness, and in particular chronic diseases, in Aboriginal populations has yet to be determined and should be the focus of further research. This should include an examination of poverty as a risk factor for chronic disease

development, as well as chronic diseases as a risk factor for poverty. This is because (WHO – chronic diseases and poverty):

Chronic diseases inflict an enormous direct and indirect economic burden on the poor, and push many people and their families into poverty. Further, the death or illness of parents or caring adults can lead to the impoverishment of their children and/or their community. Existing knowledge underestimates the implications of chronic diseases for poverty and the potential that chronic disease prevention and health promotion have for alleviating poverty (World Health Organization, 2008).

As this quote highlights, the prevention of chronic diseases and interventions targeting underlying social determinants of health have the potential to greatly improve poverty rates and the general well-being of Aboriginal Peoples.

2.1.2 Shelter and Housing

In addition to and interrelated with issues of income are issues related to shelter. Like income, housing disadvantages have been acknowledged as having potentially negative health impacts (Carson et al., 2007). Housing disadvantages can be measured and are expressed in different ways. For example, homelessness is often noted as being an extreme housing disadvantage, whereas substandard housing and the quality of a house are more moderate concerns. The gradient of housing disadvantages suffered by Aboriginal Peoples in Canada will be discussed in this section.

Homelessness among Aboriginal Peoples in Canada

Using the poverty terminology, homelessness has been characterized according to its extremity: absolute, relative, or at-risk homelessness. Within these parameters, absolute homelessness refers to:

“People without shelter who may or may not live on the streets; some may rely on emergency shelters, transitional housing, friends and families. It also includes “couch surfers. These are people without shelter that sleep in different homes whenever they can (Helin, 2002).”

“Relative Homelessness” refers to the circumstances where people have a physical shelter, but the shelter does not meet basic health and safety measures (Hwang, 2001). Those at risk of homelessness are those who are socio-economically disadvantaged and are struggling to pay rent (Helin, 2002). The working poor is a prime example of such a group, as they continually “live on a precipice that can tumble them into homelessness at any time” (Plumb, 2000). The labelling of homelessness as “situational (or temporary) homelessness; episodic homelessness; and chronic (long-term)” (Beavis, Klos, Carter, & Douchant, 1997) has also been used. While different from the lingo used in the poverty literature, this categorization is more intuitive than the absolute and relative terms.

The literature demonstrates that homelessness is experienced by Indigenous populations around the world, although it does not occur equally across all Indigenous populations. Indigenous populations that disproportionately suffer from homelessness include: Native American veterans, Indigenous Peoples living in the Northern Territory of Australia, and Aboriginal Peoples in large

cities across Canada (Carson et al., 2007; Hwang, 2001; Kaspro & Rosenheck, 1998). While it has been documented in the literature that patterns of migration have led to an increase in the number of urban Aboriginals and Aboriginal homeless. Consider the following quote:

“Increasing patterns of migration among Aboriginal people from the reserve to urban centres has led to a dramatic increase in the number of Aboriginal people now permanently residing in urban areas. Anecdotal and statistical evidence indicates that Aboriginal people are consistently and disproportionately represented among the homeless in most major Canadian cities and have unique cultural needs. No one can say with certainty the scope of the problem nor, can any accurate figure be quoted regarding the Aboriginal homeless population (Helin, 2002).”

In Toronto, however, the media has reported that twenty-five percent of Toronto’s homeless population are people of Aboriginal ancestry (Wente, 2000). With the knowledge that Aboriginal people make up only about 2% of Toronto’s total population, the disproportionate representation of Aboriginal People in Toronto’s homeless is evermore clear (Wente, 2000). Other numbers that suggest that Aboriginal people make up 15% of the homeless population still highlight the disproportionate number of Aboriginal homeless people in the city (Mayor’s Homelessness Action Task Force, 1999). Since these numbers do not include the projected or at-risk populations, it is thought that the numbers could escalate by about 8000 people (Mayor’s Homelessness Action Task Force, 1999).

In order to get a better picture of the Aboriginal homeless population in, Street Health has conducted a number of surveys of the homeless population and has developed strong links to this community. The 2007 Street Health Survey (the most recent survey) found that Aboriginal people accounted for 15% of the homeless population; a huge number based on their citation of the 2001 Census, which suggested that Aboriginal people represent only 0.5% of the general population (Street Health, in press). Information gained from the survey of this population is summarized below. It is also recommended that those interested consult the Street Health Report 2007 Research Bulletin #3: Aboriginal People & Homelessness (Street Health, in press). The demographics and composition of the Aboriginal population surveyed by Street Health are demonstrated by the following figures: (1) the average age was 38 years, with a range of 25-49; (2) 31% were born in Toronto; (3) 20% identified as lesbian, gay, bisexual, or trans-gendered; (4) 39% had completed high school and of those 15% had a college or university degree; (5) 33% live on \$2,400 or less per year; (6) 20% are employed – 4% work part-time and 16% reported doing casual or piece work, while none reported full time work; (7) survey participants had been homeless an average of 4.7 years; (8) 15% reported an Aboriginal language as their mother tongue; and (9) 27% reported having a status card. While the report produced by Street Health demonstrates that Aboriginal Peoples are disproportionately represented amongst the homeless population, the literature also shows that Aboriginal Peoples are at an increased risk of becoming homeless (Helin, 2002). As defined in the Greater Vancouver Regional District (GVRD) Aboriginal Homelessness Study 2003 (Dappleton Research Team, 2003), an urban Aboriginal person is at-risk of becoming homeless if they: pay more than 25% of their income on housing; suffer from an acute life crisis; are at risk of losing accommodations; have a household income that is below Statistics Canada’s Low Income Cut-Off; have low education levels; have been denied opportunity to access social housing; suffer from mental health issues; are hard to

house; use food banks frequently; and, are engaged in the sex trade (Dappleton Research Team, 2003).

Homelessness and Health

As the above section has shown, Aboriginal Peoples are disproportionately represented in the overall homeless population, and are at a greater risk of becoming homeless. The implications of this for the health of Aboriginal Peoples in Canada is important to consider, as the literature has shown that homeless people have higher than average levels of morbidity and mortality and often experience greater barriers to accessing safe and effective health care and health services. In fact, it has been noted that the homeless are at an unacceptably high risk for many preventable diseases, unnecessary health complications, and premature deaths (Plumb, 2000). The relationship between homelessness and health is reviewed in greater detail below.

Risks related with homelessness, such as exposure to the elements, poor nutrition, lack of support, poor access to health services, stigmatization, etc. can negatively impact the health and well-being of individuals and families living on the streets. In fact, homeless people are more likely to have chronic and severe medical conditions than the general population (Hwang & Bugeja, 2000). Health conditions among the homeless are often chronic because treatment and access to treatment is limited, sporadic, or inaccessible. Disease severity is also enhanced by the living conditions and circumstances related to homelessness (Hwang, 2001). Some of the most commonly cited health problems among the homeless are: seizures, chronic obstructive pulmonary diseases, and musculoskeletal conditions (Hwang, 2001). Statistics from the 2007 Street Health Research Bulletin #3: Aboriginal People and Homelessness comparing the prevalence of several chronic diseases to the general population demonstrates the high risks that Aboriginal homeless people face for developing chronic conditions.

Table 1. Chronic Disease Prevalence in the Aboriginal population versus the General population
Source: (Street Health, in press)

Disease	Homeless Aboriginal people	General Population*
Arthritis or Rheumatism	43%	14%
Heart disease	35%	4%
Chronic Obstructive Pulmonary Disease (COPD)	24%	1%
Asthma	22%	6%
Diabetes	22%	4%

Note: Data for the general population was drawn from the Canadian Community Health Survey (CCHS) Cycle 3.1 (2005). This analysis is based on Statistics Canada's Canadian Community Health Survey, Cycle 3.1 (2005), Public Use Microdata File, which contains anonymized data. Street Health prepared all computations on these microdata and the responsibility for the use and interpretation of these data is entirely that of the author.

In addition to these more common chronic diseases, homelessness is often thought to be related to the development and persistence of mental health conditions. While not always discussed or measured in terms of their chronic or long-term nature, mental health issues among the homeless is important to mention here. Research done in non-Indigenous populations, demonstrate that

individuals with chronic mental illnesses are at greater risk for homelessness than individuals without (Folsom *et al.*, 2005). The table below demonstrates the high prevalence of some common mental health conditions among Aboriginal homeless people.

Table 2. Most common mental health diagnoses reported by Aboriginal people who are homeless

<i>Mental Health Diagnosis</i>	<i>%</i>
Depression	16%
Anxiety	11%
Addiction to drugs/alcohol	11%
Bipolar (manic depressive)	7%
Post traumatic stress disorder	6%
Panic disorder	6%
Schizophrenia	0%

Source: (Street Health, in press)

Despite the truth of this and the correlation between Aboriginal and non-Aboriginal people's mental health concerns, some differences between the two groups suggests that more research is needed in this area. For example, Native American homeless veterans experienced fewer psychiatric problems and significantly more alcohol-related problems than non-Native homeless veterans (Kasproff & Rosenheck, 1998). Overall, unfortunately, Aboriginal people who are homeless report alarmingly high levels of social isolation and extremely low levels of social support. Drugs and alcohol are often used to help people cope with illness, trauma, or pain, and to relieve isolation. Given the harsh daily realities of homelessness and the legacy of historical violence and exclusion that too many Aboriginal people in Canada live with, the high levels substance use and self-medication reported by Aboriginal people who are homeless are sadly not surprising. As reported by Street Health (in press), Aboriginal people who are homeless have high levels of substance abuse. For example, the 2007 survey reported that: 92% smoke cigarettes and, of those, 89% smoke daily; 77% used an illicit drug other than marijuana regularly in the past year; 26% had injected drugs in the past year; 29% had at five or more drinks on one more occasion at least once a week in the past year; and, 15% had consumed non-beverage alcohol in the past year.⁵

In addition to the high prevalence of chronic diseases, both physical and mental, among Aboriginal homeless people, chronic diseases are often left undetected for years and are poorly controlled. Both of these situations can lead to premature mortality and excess morbidity (Hwang, 2001; Hwang & Bugeja, 2000). For instance, diabetics noted great difficulties with managing their diet and dealing with scheduling and logistics associated with personal care (Hwang & Bugeja, 2000; Plumb, 2000). Further, the Aboriginal homeless population in British Columbia has a death rate that is 2.1 times higher than the rest of BC (Helin, 2002). Concerns with the health of homeless people are also evident in their use of the health care system. Homeless people are admitted to hospitals five times more than the general population, often through emergency rooms, and stay in hospital more often than other lower-income patients

⁵ Non-beverage alcohol is alcohol in a form that is not meant to be consumed and includes things like mouthwash, hand sanitizer, cooking wine, and rubbing alcohol.

(Hwang, 2001). Not only do these frequent and prolonged stays in hospitals result in high health care costs, but they also make for short-term patchwork health care that does not facilitate preventative and comprehensive health care treatment

Substandard Housing

Poor housing conditions, overcrowding, inadequate housing supply, and lack of property ownership are prevalent in many Aboriginal communities. For these reasons and others, housing in Aboriginal communities are often substandard. A review of these housing issues and their impact on health is provided below to better understand the connection between housing and Aboriginal health in Canada.

The type of housing in First Nations communities varies, but a large proportion of on-reserve housing is old and/or in need of upgrading and better maintenance. According to the 2002/03 Regional Health Survey, one-third (33.6%) of First Nation homes are in need of major repairs. Another third (31.7%) need minor repairs. While the presence of household incomes below the \$20,000 cut-off were more likely to require repair and more regular maintenance, rates varied with income brackets and were still considerable high (26.4%) in more moderate income brackets (\$50,000-79,999) (First Nations Centre, 2005). These figures suggest systemic and underlying concerns with housing across all sectors of Aboriginal society. The fact that statistics documenting the number of houses in need of repairs have significantly increased since those reported by the 1985 Neilson Task Force (First Nations Centre, 2005) is concerning for the future; so is slow progress of housing improvements noted by the 2002/03 RHS survey participants (First Nations Centre, 2005). In addition to concerns with housing construction and maintenance are concerns about the supply of housing. In 2001, Indian and Northern Affairs Canada (INAC) reported a shortage of 8,500 unites on reserves (Government of Canada, 2003). The Assembly of First Nations estimates, however, that there are 80,000 backlog units (First Nations Centre, 2005). The potential impact that this housing profile may have on health is exemplified by their potential to create the conditions for mould growth, poor indoor air quality, and poor ventilation. Not surprisingly, these health concerns tend to aggravate the respiratory system, reduce lung function and growth, and lead to chronic respiratory problems (Anto et al., 2001; Cardinal, 2004).

Mould can exist and grow on and within the structure of the home. It has been found that moulds can produce allergies, asthma, eye and throat irritation, otitis media, and other upper and lower respiratory tract conditions (Daigler, Markello, & Cummings, 1991; First Nations Centre, 2005; O'Neil, 2000), but it is not clear how these interactions actually occur and whether there is a direct relationship between mould and specific respiratory conditions (First Nations Centre, 2005). Research has concluded, however, that a focus on mould problems does have the potential to help improve acute and chronic health conditions in communities where mould is found to be prevalent (O'Neil, 2001). As mould requires moisture to grow and thrive and about ½ of First Nations homes are in need of repair, the potential for a large prevalence of mould in Aboriginal homes is very real. Further, the less ventilation, the greater the potential for mould growth. While there are measures to ensue evacuation of homes with overactive mould growth or with contamination levels that exceed the standard levels, these measures and controls are not present on reserves. This is largely due to the fact that there are few health authorities in First Nations communities with the skills to do this and the lack of alternative accommodations available to

accommodate people presently living in unfit homes to (First Nations Centre, 2005).

Issues related mould and ventilation affect the overall air quality of homes. While outdoor air quality has received a lot of media attention in the past two decades (see section 2.2.4), the potentially harmful effects of indoor air pollution is often overlooked. Such pollution is common in Aboriginal communities, where wood and coal burning stoves are still used, where tobacco is used for ceremonies and meetings, and where mould and poor ventilation are prevalent. The presence of these factors cause concern for the health and well-being of Aboriginal Peoples in their homes. Through evidence of home and workplace exposures to tobacco smoke, Greer (Greer, Abbey, & Burchette, 1993) demonstrated that indoor environments have a stronger effect on the development of respiratory problems than do outdoor air pollutants. In addition to tobacco smoke, research has shown that indoor air quality may increase the prevalence of allergies and asthma (Canadian Institute for Health Information, Canadian Lung Association, Health Canada, & Statistics Canada, 2001). The prevalence and incidence of tuberculosis and other respiratory conditions has been equated with indoor air quality (cite?). Since tobacco smoke and mould are the only consistent indoor factors associated with chronic conditions, more research into the influence of indoor air pollution and its various components deserve greater attention from the research community.

The potential influence of indoor air pollution on health in the future is evidenced by studies that show that Aboriginal people are spending more of their time indoors (First Nations Centre, 2005). The particular impact that indoor air pollution has on some of the most vulnerable subsets of the Aboriginal population, such as the elderly, young children and the chronically ill (who also tend to spend even more time indoors than the average individual) will also be important to consider.

In order to conclude this discussion about air quality, it is important to note that indoor and outdoor air quality (see section 2.2.4 below) are often discussed separately. While such a distinction is important to consider, it is also important to acknowledge the connection between the two: “the average house offers little protection against aerosol, particulate, and gas contamination in the general air” (First Nations Centre, 2005); poor housing offers even less. While some Aboriginal communities have reported concerns with outdoor air quality as a result of location near industrial sites, the fact that many reserves are located in rural and remote areas means that concerns related to smog are potentially less prominent. This means, however, that home contamination may be a greater concern for Aboriginal communities, families, and individuals (First Nations Centre, 2005).

In addition to the impact that air quality issues resulting from poor housing structure, ventilation, indoor air pollutants, and outdoor particulates have on health, crowding has also been found to aggravate the respiratory system, encourage respiratory disease transmission, and facilitate the development of chronic conditions. Unfortunately, issues of occupant density (i.e. overcrowding) have been reported in Aboriginal communities (First Nations Centre, 2005). In general, a house is considered to be overcrowded if the density exceeds one person per room. The overall room density in Canada, as reported by the 2001 Census is 0.4 persons per room (Health Canada, 2002), whereas the RHS reported an average density rate of 0.76 (First Nations Centre, 2005). This translates to an average of about 2.6 people per house in the general population and 4.8

people per house in First Nations homes (First Nations Centre, 2005). In some cases, occupancy in First Nations communities was extremely high; the highest number of people per house reported by the RHS was 18 (First Nations Centre, 2005). While statistics vary in the proportion of Aboriginal homes that are overcrowded (from 12% to 17.2%) (First Nations Centre, 2005; Indian and Northern Affairs, 2005), it is certain that homes in Aboriginal communities, on average, have more people per room than the Canadian population (First Nations Centre, 2005; Health Canada, 2002). Because research has also shown that this high proportion of overcrowding impacts an individual and community's health and well-being, household crowding is a significant concern. For instance, it has been documented and recognized that night-time crowding is a significant risk factor for both upper and lower respiratory tract infections within an Inuit population in Greenland (Koch *et al.*, 2003); other studies in Aboriginal communities have also shown that overcrowding and respiratory distress are related (Fraser-Lee & Hessel, 1994). Statistics from the 2002/03 RHS report that 1 in 3 of all respondents once diagnosed with tuberculosis (TB) live in an overcrowded house. Concern for the long-term impacts of crowding on health is evidenced by the fact that 24.6% of homes with children surveyed for the 2002/03 RHS were overcrowded (First Nations Centre, 2005).

Home ownership and renting patterns are also important factors to consider when examining housing conditions among Aboriginal Peoples in Canada. Differences between Aboriginal and non-Aboriginal housing is clear when comparing ownership, renting, and social housing. It has been reported that in the general population, 65% of families own their homes; the majority of the remainder rents, while few rely on social housing (Statistics Canada, 2001). In the First Nations population the situation is reversed: "61.9% of on-reserve families live in band-owned housing which is analogous to social housing" (First Nations Centre, 2005). Comparatively, 74.1% of First Nations people living in the provinces with an income below \$10,000 and 64.4% with incomes below \$30,000 live in social housing. Households with incomes from \$30,000-80,000 also report living in band-owned homes (First Nations Centre, 2005). The high rate of occupancy of band-owned housing is a result of poverty, banks not extending mortgages to on-reserve residents, and some geographic concerns that hinder construction access and cost. A health concern with band-owned housing for First Nations communities is the high percentage of mould and mildew reported (48.7%). Reports of 36.9% in other types of First Nations is also a concern (First Nations Centre, 2005). Because the urban population tends to rent more than the general population, similar issues surface regarding mould and potential concerns with air quality and outstanding structural issues (Beavis *et al.*, 1997). As such, concerns with poor air quality and mould are equally true in these circumstances.

The close connection between one's environment and their socioeconomic situation reasserts the need to involve broader socio-cultural issues and to account for changes in air quality over time. As aboriginal communities continue to report evidence of poor air quality, poor housing conditions, indoor air pollution, crowding, and poverty, targeted research is urgently needed to investigate the impact that these factors have on Aboriginal health and their relationship to chronic respiratory disease.

2.2 Geographic Risk Factors

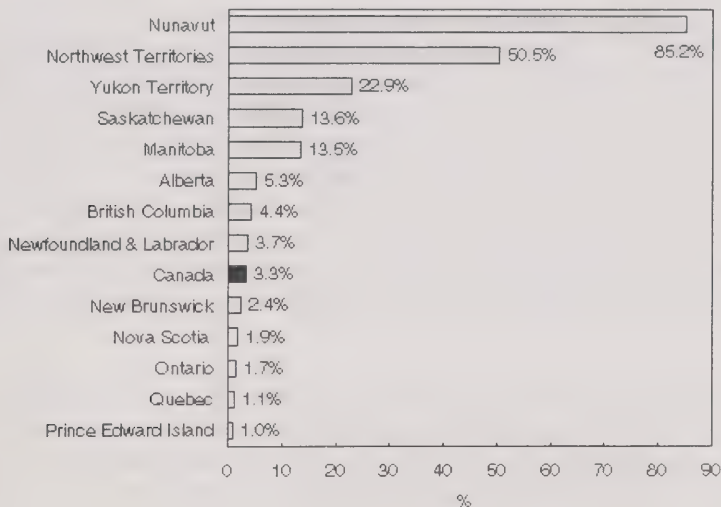
In addition to the economic status and housing conditions of Aboriginal Peoples, geographic

location can exacerbate overall health and well-being by reducing access to facilities, supplies, and support services. The quality and nature of the land can also determine the health of a population. These aspects are discussed below.

2.2.1 Community Location

Geographic location can be a key indicator of the health and well-being of a community. In order to investigate the relationship between location and health, regions are often classified according to their population density, proximity to an urban centre, amenities, and/or other communities, and the accessibility of the community. Community location and accessibility can be classified as inner city, urban, suburban, rural, remote, and isolated. While these terms have no standardized definition, most definitions are based upon accessibility issues such as distance from large urban centers, road or plane accessibility and telephone or internet access. Directional terms are also used: mainly north and south in terms of density and accessibility differences, and can be combined (e.g. northern-isolated). As demonstrated by the figure below the Aboriginal population of Canada is situated in every province and territory, and makes up the majority of the population in Nunavut and the Northwest Territories, and is a large portion of the population in the Prairie Provinces.

Figure 3. Population reporting Aboriginal identity according to their percentage of the total population, Canada, provinces and territories, 2001



Source: (Canada, 2001)

While this figure is somewhat misleading – it does not provide the population numbers – it does demonstrate the significance of the North for many Aboriginal Peoples and the higher proportion of Aboriginal People in the more traditional/rural prairie provinces of Saskatchewan, Manitoba, and Alberta. The term “rural” is often used to refer a community or personal residence that is far from a large urban centre, amenities, and/or other communities. While term “remote” is often used to refer to communities and locales that are only accessible in certain seasons (i.e. ice road communities), by air, or by gravel or unkempt roads. Since this is a reality for many Aboriginal

Peoples in Canada, the health impacts of this situation are important to review.

Regardless of ethnicity, rural location has been found to be associated with poor nutrition, inactivity, and high smoking rates (CIHI, 2006). These risk factors are generally higher among the average rural population than they are among their urban counterparts (CIHI, 2006). Rural residence, particularly if it is coupled with socioeconomic risk factors, can also decrease health care access (see section 2.2.2 below for more details). Despite these negative statistics, conflicting views persist as rural and remote residency has been shown to be beneficial to the health and well-being of Aboriginal Peoples in Canada. This is particularly true when rural living is equated with Northern living. This is because studies have shown that Aboriginal northerners report lower levels of chronic diseases than other territorial residents (Tjepkema, 2002). Further, the off-reserve Aboriginal population living in the territories was found to have a lower prevalence of chronic diseases than their provincial counterparts (Tjepkema, 2002). This pattern seems to indicate that Aboriginal Peoples living in the north may not have been exposed to the same lifestyle changes, or have experienced them to the same degree, as southern Aboriginal communities (Tjepkema, 2002). Contradiction in the evidence can be explained by the fact that trade-offs exist between the accessibility of a community and the isolation of the community; namely, the potential negative impacts of colonization versus accessibility to amenities, and opportunities for employment. Competing influences could include the positive benefits of more isolated and self-sufficient communities versus the isolation of the community from outside influences.

In addition to the different environments experienced by Aboriginal Peoples living in rural and northern communities versus urban or suburban, is the difference between on-reserve and off-reserve living. Because of increasing migration of Aboriginal Peoples to the cities, approximately 30% of Canada's Aboriginal population lives on reserve (CBC, 2003). Reserve settings have been shown to have a particular impact on health. Despite the great benefits of community and social development that a reserve may have to offer, they remain largely governed and controlled by the Canadian government. A relationship has been shown to exist between governance and health, where self-government support healthy environments and lack of control over governance issues have been equated with unhealthy behaviours and an unhealthy environment (Chandler & Lalonde, 1998).

As this brief discussion demonstrates, Aboriginal peoples living on reserve, in the Northern territories, or in other remote regions of the country are exposed to the complex of risk factors associated with their geographic location. In both reserve living and rural or northern living, access to services is a key concern. Literature examining the impact of access issues is discussed in detail below.

2.2.2 Access to Quality Health Care

As noted in the above two sub-sections, a community's access to health care and other health services is an important dimension of its health profile. In this case, access to quality health care refers to the availability of "western" primary health care provisions. While access to the western bio-medical system is important, it is also important to remember that some Aboriginal people may utilize these services in tandem with traditional health practices, only in certain context, or only for particular reasons (First Nations Centre, 2005). Issues of access are important when examining the health of populations because it has been reported in the literature that countries

with better primary health care access are less likely to report health inequities (Mackinko, Starfield, & Shi, 2003). It is also important because the research shows that insufficient health care access and performance services can contribute to lower survival rates and higher mortality rates in certain populations. Seeing as the Aboriginal population in Canada has experienced severe health inequities compared to the non-Aboriginal population, access to services and care is an important determinant of health to investigate within this population.

The 2002/03 Regional Health Survey provides some information of health care access. For instance, participants in the survey were asked to rate their health and health care access. The relationship between these two factors is reviewed below.

“First Nations respondents who rate their health as being very good or excellent estimate their access to health services as being better (24.6%) or the same (45.5%) as Canadians. Those reporting fair or poor health were less like to report having the same level of access than those in good, very good, or excellent health. (First Nations Centre, 2005).”

Differences were not found to be significant between the genders and across different age groups. Respondents with higher education, however, were more likely to rate their access to services lower than that of the general Canadian population (First Nations Centre, 2005).

Data from the Canadian Community Health Survey (CCHS) and the Aboriginal Peoples Survey also provide some interesting figures on the health care access of the off-reserve and on-reserve populations of Canada. For instance, data from the 2000/01 survey reported rates of contact with general practitioners among the off-reserve Aboriginal population. The survey stated that:

“78.8% of the off-reserve Aboriginal population reported seeing a general practitioner at least once in the previous 12 months, a proportion significantly different from that of the non-Aboriginal population. However, the Aboriginal population living in the territories was much less likely to have contact with a general practitioner than other northern residents (58.8% versus 75.9%)”

(Tjepkema, 2002).

The low rates of northern Aboriginal peoples' contact with a regular doctor were more evident when compared with non-Aboriginal northerners: 31.1% of off-reserve Aboriginals had a regular doctor versus 67.0% of non-Aboriginal northern residents. While less provincially based Aboriginal people also reported having a regular doctor as well, the difference between the Aboriginal and non-Aboriginal population in the provinces was less (Tjepkema, 2002). Interestingly, “[c]ontact with nurses were somewhat higher for Aboriginal people living in the provinces and much higher for those living in the territories” (Tjepkema, 2002). This is likely the result of the smaller community model, where community health centres are largely run and staffed by nurses. Taking into account these differences and discrepancies, it is not surprising that Tjepkema (2002) found that the off-reserve Aboriginal population cited more unmet health needs than the non-Aboriginal population. Similar results were found for the on-reserve population. The Aboriginal Peoples' Health Survey 2001 revealed that Aboriginals residing on reserves were “less likely to have seen a physician” or other health professional (68%) in the past

year (61%) compared with the urban population (73% and 77% respectively). In addition, the proportion of Inuit who have seen a physician" (47%) or other health professional (57%) in the past year was found to be the lowest among all of Canada (Newbold, 1998).

A number of barriers have been cited with regards to the accessibility of health services to Canada's Aboriginal population. While some of the concerns vary depending on an individual or community's location, others are broader reaching. In on-reserve, northern and rural areas the lack of local services, lack of access to a physician or other health provider, the need to travel to get to a health facility and receive medical treatment are often cited as major barriers to adequate health care (First Nations Centre, 2005). Similarly, but more broad-reaching, are economic concerns related to issues of transportation, child care, and the direct costs of some health services. Cultural barriers, such as the lack of culturally appropriate or relevant care and issues with accessing traditional care, are also commonly cited. Finally, systemic issues include, being denied approval of service under the Non-Insured Health Benefits (NIHB) system or not having NIHB coverage, and long waiting lists continue to plague many Aboriginal people, families, and communities (First Nations Centre, 2005). Seeing that the purpose of the NIHB is to help First Nations reach an overall health status similar to the general population of Canada, data such as this suggests that the NIHB program acts as a barrier to accessing care.

The need for local and culturally appropriate services are important in the discussion of barriers to access for Aboriginal Peoples in Canada. Evidentiary support for this is available in the reports calling for better health access for communities with a health transfer agreement⁶ (First Nations Centre, 2005). The health transfer policy enables more community control and, therefore, more culturally appropriate, culturally relevant health, and locally available services. Interestingly, "respondents from communities that transferred as part of a multi-community transfer are more likely to rate their access to health services as generally less than Canadians" (First Nations Centre, 2005). This finding calls into question the effectiveness of the health transfer system, suggesting that further research is required to assess this policy and the implications that it has on health access, health status, and general well-being.

Diagnostic, Screening, and Prevention Services

The availability of diagnostic, screening, and prevention services are often seen as indicators of health care access and performance. As such, the availability of these services in Aboriginal communities will be discussed below.

In the area of cancer; diagnostic services, screening, and preventative interventions are thought to have a great influence on incidence, mortality and survival rates. Participation of the Aboriginal population in cancer screening programs remains lower than that of general population is concerning (Kue Young, Kliever, Blansharg, & Mayer, 2000). Screening for cervical cancer in First Nations women through a pap smear test has traditionally been reported as being low (Clarke *et al.*, 1998). Data from the 2002/03 RHS, however, shows that the level of coverage of Pap smear testing is relatively similar between the Aboriginal and non-Aboriginal populations. While this is a great improvement, the RHS stats that: "*given the disproportionate mortality rate*

⁶ The health transfer policy was officially adopted by Health Canada in 1989 and continues today. It enables First Nations communities to control the allocation of resources for particular programs and services, thus, providing opportunity for greater autonomy and community control over health care.

of First Nations women experiences as a result of cervical cancer, it would be advisable to strive for more systematic First Nations-specific screening programs" (First Nations Centre, 2005). Other research has found that in addition to issues related to access to cancer screening programs, lack of awareness of available programs and services contributes to issues related to cancer screening (Condon, Barnes T., Armstrong B.K., Selva-Nayagam S., & J.M., 2005). Thus, education and awareness should be considered an integral part of strategies to improve screening programs. Other issues related with the low uptake of certain cancer screening tests, such as the digital rectal exam (DRE) require further examination (First Nations Centre, 2005).

In addition to cancer, a lack of or delayed blood sugar testing among Aboriginal Peoples is thought to be connected to the rise in diabetes mellitus in this population. The 2002/03 RHS noted that less than 50% of at risk age groups had been screened for diabetes in the last 12 months (First Nations Centre, 2005). Given the epidemic proportions of diabetes in the Aboriginal population today, these numbers are far too low. Testing for cardiovascular diseases, such as cholesterol tests and blood pressure exams are also lower than is desired: cholesterol testing is low across all age groups, while blood pressure tests are being accessed at higher, but not ideal, rates (First Nations Centre, 2005).

2.2.3 Climate Change, Outdoor Air Quality, and Environmental Contaminants

The importance of the environment on health has received increased attention in recent years as a result of greater public awareness and debate about the issues surrounding climate change. Because Indigenous societies are traditionally very connected to the land, issues related to climate change are amplified in Aboriginal contexts (Paci, Dickson, Nickels, Furgal, &, 2004)). The location of many Aboriginal communities in northern and remote regions make the impacts more obvious. Global warming and environmental changes such as melting ice are much more visible than observed in southern regions of Canada.

Outdoor air quality concerns have been central to discussions about climate change and the connection between the environment and human health. In response to a rising public concern for "new pollutants"⁷ in the 1980's, research related to environmental conditions has focused on the presumed association between an increase in hazardous particles in the air and incidences of respiratory problems (Strachan, 2000). This hypothesis has been corroborated by studies of non-smoking cohorts (Abbey *et al.*, 1995; Greer *et al.*, 1993), which have found significantly higher incidences of asthma and chronic respiratory symptoms among people with high cumulative exposures to particulates and ozone. The considerable influence of outdoor pollutants on human health and its potential as a risk factor for chronic respiratory disease, however, should not overshadow the potential role that indoor air pollution plays in an individual's respiratory health (Anto *et al.*, 2001).

Environmental concern with contaminants and the impact of industrial bi-products, chemicals, and other particulates on human health are connected to discussions of the impact of air pollution. A key concern for many First Nations and Inuit communities is exposure to polychlorinated biphenyl (PCB). The PCBs are suspect as being responsible for increased cancer incidence rates and other health issues. PCBs accumulate in tissues along the food chain, and

⁷ The term, "new pollutants" is used to refer to hazardous particles and gasses (i.e. greenhouse gases) from vehicle emissions, industrial processes, and commercial practices.

Aboriginals who consume fish as part of their traditional diet have been found to have a very high concentration of PCBs in their body fat. Nursing Inuit women living in northern Quebec been observed to have seven times the PCB concentration in their breast milk than that of Canadian women (MacMillan et al., 1996). Moreover, the breast milk of these Aboriginal women was found to have the highest PCB concentration in the world. At the same time, the Government of Canada has reported that the PCB concentration required to cause cancer is far greater than any possible environmental exposure (Health Canada, 1994; Murray, 1994). Mercury accumulated in fish tissues is a concern for many Aboriginal communities, especially those that rely on fish as a primary food source (Van Oostdam *et al.*, 2005). Inorganic and methyl mercury have been designated probable carcinogens, which present at high concentrations are thought to increase cancer risk. According to a study involving Inuit living in a Baffin Island community, their daily intake of mercury averaged 65 mg for women and 97 mg for men, which is much higher than the mean daily intake of 16 mg for mainstream Canadians (MacMillan et al., 1996). Since mercury has been linked to other health conditions, such as central nervous system problems and learning disabilities, this is a key concern for the future health and well-being of Aboriginal Peoples.

The challenge with environmental contaminants is that they are often found in “traditional” or “country” foods; the general category used to describe all of organic plant and animal nutrients that ensure and maintain the health of Aboriginal Peoples (Paci et al., 2004)). In Canada, common counter/traditional foods are fish, wild game, berries, and other gathered vegetables, fruits, and grains. The importance of discussing the past, present, and future gathering and consumption of traditional/country foods among Aboriginal Peoples in Canada is that they can be protective factors for many chronic diseases. The correlation between the consumption of country foods and better health is also a result of the higher nutrient value of these foods and the exercised associated with the hunting and gathering required to obtain them. The consumption of country foods is also beneficial for warding off the increased presence of “modern foods” (i.e. convenience and fast foods, simple sugars, etc.) in Indigenous diets. While these modern or western foods have been assimilated into Indigenous communities at different times, speeds, and intensities (Paci et al., 2004)), their presence is now common and widespread. In addition to encouraging the reduction of traditional foods in Indigenous diets, these cheap and easy foods are unhealthy in and of themselves: pop, chips, and other “empty-calorie” foods do not provide children, parents, and/or grandparents with the nutrients, vitamins, and minerals that they need to survive and thrive.

The problem is the risk of tradition food needs to be balanced by the risk of store bough food. Clearly, food security is a very important issue as good food is key to optimal development, especially in infants and young children. Greenhouse gas emissions and society’s carbon footprint on the health of the land and concerns with the fuel cost and logistics for the transportation of food to rural and remote communities, such as many First Nations reserves, Metis and Inuit communities, are reasons to encourage the consumption of country foods. It is imperative that we find more innovative ways to ensure a balance between food availability, diversity, and quality for all Aboriginal and non-Aboriginal people in Canada.

Finally, as this is just a brief overview, more information about the increasing role of environmental risk factors and their relation to an increase of chronic diseases in many

Aboriginal communities deserves greater research attention (Lawrence & Martin, 2001).

3. Prenatal Risk Factors

The term “prenatal risk factors” is used here to denote those that occur, exist, or act on the individual prior to birth. As such, prenatal risk factors are associated with the health of the mother and unborn child. Included in this section, therefore, is a discussion of maternal diabetes, maternal obesity, maternal smoking, and maternal alcohol use. While birth weight is often an indicator of intrauterine effects, birth weight will be explicitly discussed in the natal risk factor section, which follows this section. It was placed in the natal section, as it is measured at the time of birth and impacts the infant’s health and its chronic disease risk.

3.1 Maternal Diabetes

First Nations women represent roughly two-thirds of the First Nations people who are diagnosed with diabetes (Bobet, 1997), while the reverse is true in the general Canadian population (Health Canada, 1999). In addition to experiencing an overall higher prevalence of type 2 diabetes (First Nations Centre, 2005), many First Nations women are also diagnosed with gestational diabetes mellitus (GDM) (Mohamed & Dooley, 1998), which is defined as any degree of glucose intolerance for which the onset or first recognition occurred during pregnancy (Matthews, 2003). The purpose of this section is to review the impact that high rates of GDM in Aboriginal mothers has on the fetus and, therefore, the future generations.

Research shows that maternal diabetes is a strong predictor of high birth weight in newborns (Dyck, Klomp, & Tan, 2001; Godwin et al., 1999; Harris et al., 1997; Rodrigues et al., 1999). Since the direct impacts of high birth weight are reviewed in the following section (section 3 – natal risk factors), this section will review the connection between GDM and the long-term health of the developing fetus. Looking to the research once again, one finds that in addition to increased rates of macrosomia (high birth weight; >4000g), offspring of women with GDM may also experience increased IGT, increased rates of childhood obesity, and an increased risk of Type 2 diabetes (Pettitt & Knowler, 1998; Silverman, Rizzo, Cho, & Metzger, 1998). A study of Pima Indians indicated a significant association of maternal glucose intolerance with elevated risk of diabetes in offspring (Franks *et al.*, 2006). Since maternal diabetes and high birth weight are also linked, the question is whether it is the high birth weight or the mother’s diabetes that increases the risk to the health of Aboriginal children. However, a study among Pima Indians, which examined families where siblings were born both before and after their mother was diagnosed with diabetes, demonstrated that children exposed to diabetes *in utero* had a higher body mass index (BMI) than their unexposed siblings and that their risk of diabetes was almost four times higher (Dabelea *et al.*, 2000). In a different study, it was suggested that about 40% of Type 2 diabetes among 5-to 19-year-old Pima children can be attributed to maternal diabetes during pregnancy (Dabelea & Pettitt, 2001). This discussion of maternal diabetes highlights the potentially strong impact that the fetal environment plays an individual’s health later in life.

3.2 Maternal Obesity

Some studies suggest that maternal obesity, which is often associated with GDM, may be the

overriding factor in mediating offspring obesity (Boney, Verma, Tucker, & Vohr, 2005; Whitaker et al., 1998). An American study that followed children from birth to 6-12 years found that GDM was not independently significant in increasing metabolic syndrome⁸ risk in children, but offspring of obese mothers incurred a two-fold increased risk profile. (Boney et al., 2005). If these results could be extended to Canada's Aboriginal population, pre-pregnancy and pregnancy could be seen as an extremely effective point in the life course to target obesity and thus reduce the burden of Type 2 diabetes throughout the early years and adulthood. In general, these results also demonstrate the strong relationship between maternal health and the health of a child at birth and throughout their life. The literature on the impact of another maternal lifestyle behaviour, smoking, on fetal development and chronic disease risk is discussed below.

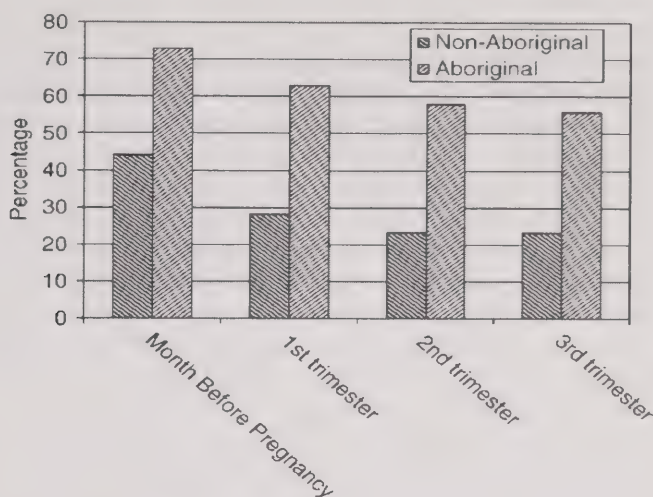
3.3 Maternal Smoking

A clear association has been shown between maternal smoking and intrauterine growth restriction in both Aboriginal and non-Aboriginal populations (Horta, Victora, Menezes, Halpern, & Barros, 1997; Power & Jefferis, 2002; Wenman, Joffres, & Tataryn, 2004). Proportions of pregnant women who smoke varies substantially among different ethnic groups. According to First Nations Regional Health Survey 2002-2003, smoking rates among pregnant First Nation women (58.8%) matched those in the general First Nations population (RHS, 2002/2003). A study conducted in Manitoba found that among 684 interviewed women a significantly higher proportion of Aboriginal women (61.2%) than non-Aboriginal women (26.2%) smoked during pregnancy; however, a smaller proportion of Aboriginal women than non-Aboriginal reported smoking more than 1 pack per day (Heaman, 2005). These findings are contrary to the results of the 2002/03 RHS, which found that Aboriginal mothers smoking more than 10 cigarettes per day was three times higher than mothers in the general Canadian (5.3% vs. 15.0%). Perhaps this means that consistent, moderate smoking is more common among Aboriginal mothers, whereas small but more extreme smoking habits are more commonly observed in the non-Aboriginal population.

In both Aboriginal and non-Aboriginal populations, the mean number of cigarettes smoked by pregnant women in both populations decreased as pregnancy progressed. This and the consistently higher rates of maternal smoking in Aboriginal populations are represented in the figure below.

⁸ Metabolic syndrome is not a disease in and of itself, but is a cluster of disorders of an individual's metabolism — including high blood pressure, high insulin levels, excess body weight and abnormal cholesterol levels — that make them more or less likely to develop diabetes, heart disease and/or a stroke.

Figure 4. Prevalence of smoking across the stages of pregnancy for non-Aboriginal and Aboriginal pregnant women in Manitoba.



Source: Adapted from (Heaman, 2005)

As explained by Heaman (2005), a number of factors influence maternal smoking habits. For example, Heaman (2005) found that there was a significant relationship between smoking during pregnancy for Aboriginal mothers with low-income, alcohol use during, low support from others, inadequate prenatal care, a family history of residential school attendance, low education levels, and location in a remote and isolated community. Conversely, having a paid job and living in communities with multi-community health services reduced the odds of smoking during pregnancy (Heaman, 2005). In addition to active smoking by mothers in Aboriginal communities, maternal exposure to tobacco smoke is important to consider. Since statistics demonstrate that the presence of smoking in the home of First Nations mothers was about one in every two families (48.2%), passive maternal smoking can be considered an important issue. The generally high prevalence of active and passive maternal smoking in Aboriginal populations is why it is important to examine the potential impact that maternal smoking has on disease later in life (Grove et al., 2001; Reilly et al., 2005; von Kries, Toschke, Koletzko, & Slikker, 2002); this is reviewed below.

Negative effects of maternal smoking on fetal growth has been well-documented as numerous studies have shown that smoking tobacco during pregnancy causes fetal growth retardation (FGR) (Cliver, 1995), which may result in low birth weight (Humphrey, 2000; Mohsin, 2005) or sometimes in preterm births (<37 weeks), stillbirths, and neonatal deaths (Chan, 2001; Kallen, 2001; Mohsin, 2005; Shah, 2000). The 2002/03 RHS found that low birth weight is linked to heavy prenatal maternal smoking (when mothers smoked ≥ 20 cigarettes per day). Smoking has also been directly associated with central metabolic syndrome and has been documented as a concern for the development of chronic respiratory diseases, such as asthma in children (Daigler et al., 1991). This is because fetal exposure to smoke can impair the proper development of the pulmonary system *in utero* (Gilliland et al., 2000; Hanrahan et al., 1992). This is why infants born to women who smoke are at the higher risk of respiratory infections and asthma compared

with infants of non-smoking mothers (Gilliland et al., 2000; Hanrahan et al., 1992; Heaman, 2005). The long-term impacts of smoking among Aboriginal mothers has also been reported. According to the 2002/03 RHS:

“children exposed to smoking during pregnancy were less often in ‘excellent’ or ‘very good’ health, were more likely to have chronic bronchitis or ear infections and slightly more likely to have asthma or allergies, compared to children who were not exposed to smoking during pregnancy. The distribution in school performance indicated a trend towards overall worse performance for infants whose mothers smoked during pregnancy (First Nations Centre, 2005).”

These long-term trends are a particular concern for the future health and well-being of Aboriginal Peoples.

3.4 Maternal Alcohol Use

The toxic effects of alcohol on the fetus may result in fetal alcohol effects (FAE) or fetal alcohol syndrome (FAS), depending on the amount of alcohol consumed during pregnancy. While debated, Health Canada suggests that regular consumption of 2 drinks a day or more is toxic to fetus and may lead to FAE/FAS (Canada, 2005).

The physical, mental, emotional and behavioural effects of fetal exposure to alcohol vary widely among affected individuals. Fetal alcohol syndrome (FAS) is generally characterized by distinct facial characteristics, growth retardation, and dysfunction of the central nervous system (Anderson et al., 2002; Society, 1998; Tait, 2003; Van Bibber, 1997; Wemigwans, 2005). Fetal alcohol effects (FAE) are the behavioural and cognitive effects observed in the absence of the physical malformations of FAS. This can cause complications for determining prevalence and incidence rates because many people affected by prenatal alcohol exposure do not display obvious physical symptoms, but instead will suffer from more cognitive and behavioural symptoms. Because these symptoms are more difficult to diagnose, they often remain undetected until the affected child goes to school. This means that the true incidence of FAE is likely much higher than the reported rates of FAS/FAE in newborns (Canadian Pediatric Society, 2002; Square, 1997). In addition to the terms FAS and FAE, the term fetal alcohol spectrum disorder (FASD) is used to encompass “the full range of outcomes observed among individuals with prenatal alcohol exposure” (Rasmussen, Horne, & Witol, 2006). This term will be generally used throughout this section to refer to prenatal alcohol exposure, unless a direct reference to FAS or FAE is provided.

Occurrence and severity of FASD symptoms are known to vary between affected individuals, but recent evidence suggests the presence of differences at the population level, between affected Aboriginal and non-Aboriginal children. The FASD literature does document some noticeable differences between the Aboriginal and non-Aboriginal population in Canada. For instance, it has been estimated that overall FAS incidence in the general Canadian population is between 2.8 and 4.8 per 1000 of live birth (Canadian Pediatric Society, 2002). Comparably, the rate of FAS in the northern Manitoba Aboriginal population was 7.2 per 1000 of live births (Canadian Pediatric Society, 2002). The 2002/03 RHS found that on a national level, the prevalence rate of

FASD among First Nations is 1.8% ([FNIGC], 2005).

Comparisons made between FASD prevalence rates between Aboriginal and non-Aboriginal Canadians, however, should be regarded with caution. This is because studies of FASD among Aboriginal Peoples have typically focused on small communities believed to be at risk of fetal alcohol exposure due to high rates of binge drinking (Tait, 2003). As such, these communities tend to demonstrate extraordinarily high prevalence rates; sometimes as high as one in five births (Van Bibber, 1997). For example, a study of alcohol use by pregnant women on Vancouver Island has found that 54% (Canadian Pediatric Society, 2002) of Aboriginal and 16% (Square, 1997) of non-Aboriginal pregnant women were found to be at risk of having a newborn with some fetal alcohol effects. In addition to research being conducted in high-risk communities, it is often thought that a number of other factors may be influencing the high rates of FASD reported in Aboriginal communities. For example, researcher expectations of documenting such high rates; more Aboriginal than non-Aboriginal women providing accurate descriptions of alcohol use during pregnancy; a greater likelihood of health professionals diagnosing FASD in Aboriginal patients; and small groups of women consuming alcohol during multiple pregnancies (Tait, 2003).

In addition to these issues, research on FASD is skewed due to the fact that the alarmingly high FASD prevalence rates among some Aboriginal communities (or clusters of individuals) are often generalized to all Canadian Aboriginal Peoples, without evidence to do so and without regard for the diversity that exists among Aboriginal Peoples (Tait, 2003; Van Bibber, 1997). As more research begins to develop across the country, in both high and low risk areas, it will be possible to get a better picture of the scope of FASD. Evidence from the States documenting that prevalence rates of FASD differ between American Indian tribes based on control and structure of government (Tait, 2003) will be important to take into account, as these differences may also influence the stratification of FASD in Canada. Since FASD is widely recognized as the leading cause of preventable birth defects in their children (Canada, 2005; Society, 1998), this issue will be important to consider with regards to the long-term health of the Aboriginal population of Canada.

4. Natal Risk Factors

“From an Indigenous perspective, each new life might be considered as an opportunity from the creator for hope and healing, for individuals, families, communities, and nations. On the medicine wheel...infants sit beside the elders. Like elders, they may be considered teachers. Elders and infants are both close to the spirit world; the infants arriving from it, and the elders traveling to it. This closeness to the spirit world may bring a spiritual strength, but it may also bring a physical vulnerability and sensitivity to environmental disturbance” (First Nations Centre, 2005).

The term “natal is generally used to refer to things relating to, associated with, or present at one’s birth. Natal health is so important because a child’s risk of dying is highest in the first month of life, when safe childbirth and effective neonatal care are essential (World Health Organization, 2007). Further, children are exposed to important risk factors for the development of chronic diseases at this stage; abnormal birth weights and breastfeeding are two that will be specifically

discussed here. As will be demonstrated by these factors below, the health of Aboriginal infants is interrelated with maternal, family, and community health.

4.1 Abnormal birth weights

In the world of Western medicine, birth weight is considered one of the most important measures of infant health. This is because birth weight can be used to measure fetal growth, to assess conditions in the womb, and to link these early life factors to health in adulthood (First Nations Centre, 2005). Several studies have illustrated the association between suboptimal patterns of fetal and infant growth and adult chronic disease. These studies lay the foundation for what is known as the “fetal origins hypothesis,” which suggests that physiologic or metabolic “programming” during gestation and infancy determines, to a large extent, the occurrence of various chronic diseases in later life (Barker, 1995, 1995, 1995; Hales & Barker, 1992). For instance, a number of studies have reported a strong link between low birth weight and the occurrence of heart disease and hypertension later in life (Barker, 1995, 1995, 1995; Barker, Osmond, & Law, 1989; Fall, Vijayakumar, Barker, Osmond, & Duggleby, 1995; Kajantie, Barker, Osmond, Forsen, & Eriksson, 2008). Historical cohort studies in England have found that impaired fetal growth, low birth weight, and lower respiratory tract infections in early childhood are associated with lower levels of lung function in late adult life (Barker *et al.*, 1991; Shaheen *et al.*, 1994). Although a 1985-86 follow-up study was unable to confirm this finding (Shaheen, Sterne, Tucker, & Florey, 1998), Barker and colleagues (1991)) added to this theory in 1991 when he found an association between lower birth weights and poorer adult lung function. The biological explanation of this association is that the intrauterine influences that slow fetal weight gain also constrain the growth of the airways and permanently effect their development and function (Barker, 2004). One problem with these studies, however, is that they often assume that a higher birth weight is healthier: this assumption does not account for maternal conditions, such as obesity and diabetes, that might cause changes in the uterine environment that will produce heavier, but not necessarily healthier, babies (Chan, Wong, & Silverman, 1990; Coory, 2000).

For instance, both high (>4000 grams) and low (<2500 grams) birth weights have been shown to be associated with increased risk for diabetes in later life (Harder, Rodekamp, Schellong, Dudenhausen, & Plagemann, 2007; Pettitt, Forman, Hanson, Knowler, & Bennett, 1997; Pettitt & Knowler, 1998). Despite increased smoking during pregnancy among Aboriginal women, which has been shown to decrease birth weights (Pirogowicz *et al.*, 2004; Wenman *et al.*, 2004), Aboriginals and Canadian populations have similar proportions of births with low birth weight (Gilchrist *et al.*, 2004). Despite high rates of maternal smoking in Aboriginal communities, First Nations babies are almost twice as likely to be classified with a high birth weight than non-Aboriginal Canadians (Rodrigues, Robinson, Kramer, & Gray-Donald, 2000). The mean birth weight for First Nations children reported by the 2002/03 RHS was 3.55 kg and the mean weight for males (3.60 kg) was higher than it was for girls (3.49 kg) (First Nations Centre, 2005). While the mean birth weight is on the higher end of the “normal birth weight” range (2.5-4.0 kg), the gender difference is not considered to be a significant finding: higher birth weight among males has been reported in non-Aboriginal populations (First Nations Centre, 2005). A major concern with high birth weight is its association with the rising epidemic of diabetes among Aboriginal Peoples (Caulfield, Harris, Whalen, & Sugamori, 1998). A recent study of First Nations births in

Saskatchewan from 1950 to 1984 showed a significant association between high birth weight (but not low birth weight) and diabetes for Saskatchewan registered Indians (OR 1.63 [95% CI 1.20, 2.24]). This trend was also found to be stronger for females than males (Dyck *et al.*, 2001). The researchers in this study suggested that excess fetal nutrition is the overriding intrauterine factor in the pathogenesis of type 2 diabetes in the Canadian Aboriginal population. As discussed earlier, the prevalence of maternal diabetes is also thought to affect birth weight. A study conducted in Saskatchewan among First Nations women found that infants from gestational diabetes mellitus (GDM) pregnancies were 2.4 times more likely to be macrosomic⁹ (95% CI: 1.1, 5.6) than their non-GDM counterparts (Dyck *et al.*, 2001). High birth weight was also found to be a factor in the development of childhood asthma. Sin *et al.* (2004) concluded that “because obesity promotes inflammations and imposes mechanical constraints to the airways, a high birth weight may be a risk factor for asthma in childhood” (Sin *et al.*, 2004). Since Aboriginal children have been documented to have higher birth weights than non-Aboriginal children (Sin *et al.*, 2004; Thomson, 1990), they may be at a greater risk of developing chronic respiratory illness early in life.

Nevertheless, it is important to not over-generalize about the prevalence of high birth weight among Aboriginal children. This is because, on the one hand, studies, such as those involving the Cree of James Bay have reported among the highest mean birth weight statistics and a high prevalence of infant macrosomia (Rodrigues *et al.*, 2000). Similarly, other studies have suggested that Aboriginal children are genetically predisposed to high birth weights (Sin *et al.*, 2004). However, poor fetal development and low birth weight has been documented in many disadvantaged and/or marginalized Indigenous communities (Blair, 1996; Chan, Keane, & Robinson, 2001), where access to basic necessities and medical care puts mothers and their infants at risk. Poor living conditions, socioeconomic problems, and inadequate maternal health care in many of Canada’s Aboriginal communities places these infants at a high risk for low birth weight (Blair, 1996; Chan *et al.*, 2001). Thus, before conclusions can be drawn about this risk factor, more research and understanding is needed (Kuh & Ben-Shlomo, 2004).

A final point must be made about the classification of birth weights. Currently, Aboriginal birth weights are classified as high, normal or low in comparison to non-Aboriginal standards. Because of potential differences between Aboriginal and non-Aboriginal populations in terms of maternal and child health, birth weight correlations should be considered rudimentary and preliminary at best. More appropriate and culturally specific measures of Aboriginal birth weights are needed in the future so that more accurate statistics can be used to assess this risk factor in the Aboriginal context.

4.2 Breastfeeding

Breastfeeding is a common topic in natal health. While the popularity of breastfeeding among mothers has varied with the times and continues to vary according to cultural contexts and perspectives, there is a growing body of literature discussing its impact on infant health and development.

⁹ To have a high birth weight (>4000g).

Health Canada encourages mothers to breastfeed because it provides infants with nutritional and emotional nurturing, as well as immunological benefits that enhance an infant's growth and development (Public Health Agency of Canada, November 1998). Breastfeeding is considered to be an important aspect of disease prevention, because infants who are breastfed have an increased protection against respiratory, ear, and intestinal infections. This is because the unique components of human milk helps protect infants from outside infection (Public Health Agency of Canada, November 1998). Reports of children who are breastfed being less likely to be overweight, more likely to be of an acceptable weight, and more likely to be in "very good" or "excellent" health. These results support literature on the perceived benefits of breastfeeding. In addition to the health benefits, breastfeeding is socially and economically advantageous, since it is an ecologically sound, efficient, economical, and self-reliant food source (Breastfeeding Committee for Canada, 2002; Public Health Agency of Canada, November 1998).

Like all babies born prior to the advent of formula, native infants were nursed until they were able to digest other food sources (Banks, 2003). Traditional breastfeeding practices, however, shifted to bottle-feeding in the 1950s when formula was introduced to the population (MacMillan *et al.*, 1996). For example, a study of Native children in Manitoba identified prolonged breastfeeding as a strong protective factor against Type 2 diabetes: a child who was breastfed for more than 12 months was shown to have only 24% of the risk of diabetes compared with the bottle-fed child (Young, Chateau, & Zhang, 2002). The protective effects of breastfeeding have also been observed in Pima Indian studies (Pettitt *et al.*, 1997; Pettitt & Knowler, 1998). Despite these studies and the fact that initiation rates for breastfeeding has increased in recent years (Langner & Steckle, 1991; Macaulay, Hanusaik, & Beauvais, 1991), the limited statistics documenting Aboriginal breastfeeding rates report lower breastfeeding rates than those of women in the general population (Dodgson, Duckett, Garwick, & Graham, 2002).

For instance, a 1988 survey conducted for the National Database on Breastfeeding among Indian and Inuit Women revealed that 60.7% of infants were breastfed at birth, but the rate dropped dramatically to 31.1% by the time the infants were 6 months old. (Langner & Steckle, 1991). A more recent study of James Bay Cree found a breastfeeding initiation rate of 51.9% among Aboriginal mothers (Black, Godwin, & Ponka, 2008). The average proportion of children reported by the RHS 2002/03 who are breastfed was 62.5% (First Nations Centre, 2005). As noted in the RHS: "This rate is higher than the previous rate (50%) reported for First Nations and Inuit (First Nations and Inuit Regional Health Survey National Steering Committee., 1999). However, it is lower than the rate (79.9%) that was reported for the general Canadian population (Statistics Canada, 1998-1999). The RHS also reported on the duration of breastfeeding: "Of the children who were breastfed, 21.6% were breastfed for 12 weeks or less, and 35% were breastfed for three to six months and 43.3% were breastfed for more than six months" (First Nations Centre, 2005). These rates were found to be higher than the rates reported from the 1997 RHS (only 22.5% reported breastfeeding for more than seven months) (First Nations and Inuit Regional Health Survey National Steering Committee, 1999). In comparison with the Canadian population, 32.5% reported breastfeeding for 12 weeks or less, 33.4% for three to six months, and 34.0% for more than six months (Statistics Canada, 1998-1999).

The socio-cultural, political, and economic forces connected to breastfeeding are complex (Banks, 2003). For instance, the success or failure of breastfeeding among many Aboriginal

women is connected to many intergenerational and community factors. Among Mohawk women, breastfeeding is strongly influenced by the baby's grandmother, who plays a key role in the child's rearing. Thus, breastfeeding rates are often low because it is an impractical form of feeding if grandmothers and extended family are to also be involved. Since bottle feeding makes the involvement of the extended family more possible and pump technology and storage is not always available, feeding practices tend to be different than among the general population (Banks, 2003). Other cultural influences, such as the availability of government-subsidized baby formula (Banks, 2003), can encourage low breastfeeding rates. Furthermore, mothers with low income, a family history of residential school attendance, and/or living in a community that had a multi-community health services agreement were lower and shorter in duration (First Nations Centre, 2005). While this information from the 2002/03 RHS is helpful, the relationship between breastfeeding and these and other factors, such as education, need to be investigated further (Breastfeeding Committee for Canada, 2002). The association reported by the RHS between high birth weight, breastfeeding, and non-smoking mothers also deserves attention (First Nations Centre, 2005).

5. Early Childhood Risk Factors

The stage known as "early childhood" refers to children aged 1 to 5 years old. This age-range is often separated out because it is during this time that children experience a phase of accelerated growth. This time period is particularly important for health because it is this growth period that has the potential to influence one's long-term health and development: "A good foundation in the early years makes a difference through adulthood, thus, giving a better start to the next generation" (World Health Organization, 2008).

While the care of children during this time is often placed on the shoulders of the parents, it is increasingly recognized that it is extremely important for service providers, planners and policymakers to thoroughly understand the significance of early childhood and to play a role in ensuring the social, economic, and biological needs of all children are met (Centres of Excellence for Children's Well-being, 2008). The need to focus on this area is so important because it is sadly the first time in history that parents can confidently say that their children are likely have a lower life expectancy than themselves (Chronic Disease Prevention Alliance of Canada, 2006). In an effort to provide increased awareness about the impacts of early childhood on chronic diseases later in life, this section will review the key risk factors for chronic diseases present for Aboriginal children. First, however, a description of the population will be provided.

5.1 Population Influences

A defining feature of the Aboriginal population in Canada is its young age and high birth rate. As a result, the Aboriginal population is the fastest growing population group in Canada (its birth rate is 70% higher than the non-Aboriginal population) (Statistics Canada, 1996) and Aboriginal children account for a large portion of the total Aboriginal population. According to a report by the Canadian Council on Social Development (CCSD) in 2002, children under the age of 14 represent one-third of the Aboriginal population, which is considerably higher than the 19% of the population that non-Aboriginal children represent (Andrerson, 2003). Further, statistics from 2002 show that Aboriginal children account for 5.6% of the total number of children in Canada,

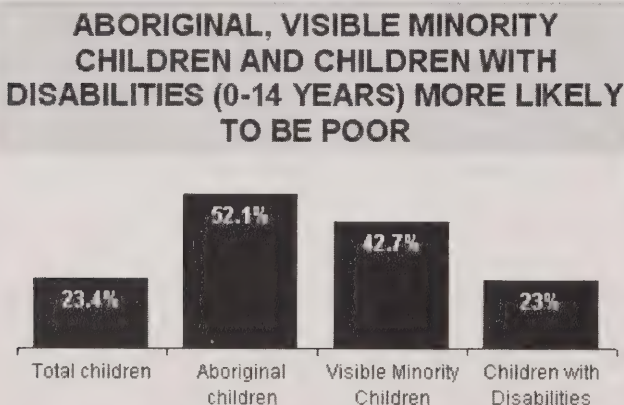
while the total Aboriginal population accounts for 3.3% of the total population of Canada (Anderson, 2003). Because of the large percentage that Aboriginal children make up of the total population and because they represent the future, their health and well-being must be considered an important area of focus. The risk factors for chronic diseases with greatest exposure and impact in childhood will be discussed here, so as to better understand the present and future health and well-being of Aboriginal children in Canada.

5.2 Child Poverty and Hunger

About 20 million children under five worldwide are severely malnourished and live in impoverished conditions. As a result, these children are more vulnerable to illness and early death (World Health Organization, 2008). While the terms poverty and hunger are often equated with developing countries, the reality of child poverty in Canada is very real: one in six children in Canada is poor. This makes for a child poverty rate of 15%; three times the rates of Sweden, Norway, and Finland (ending child poverty –MPH). Poverty among Aboriginal children is even more appalling. While some of the statistics are conflicting, approximately one in four First Nations children live in poverty (Campaign 2000, 2006). However, a report from 2001 documented that more than half (52.1%) of Aboriginal children were poor (Lee, 2000).

When statistics were broken down for on and off reserve children, the large number of Aboriginal children in poverty is evermore clear. This is because 40% of off-reserve Aboriginal children live in poverty (Campaign 2000, 2006). And, since 219,570 of the 286,500 Aboriginal children live off reserve, this means that “77% of all Aboriginal children between the ages of zero and nine” (Lee, 2000) could be considered as living in poverty. This shockingly high statistic represents the highest rate of the three “equity groups” noted in and pictured by the figure below (Lee, 2000).

Figure 5. Prevalence of Child Poverty in Aboriginal Children, Visible Minority Children, and Children with Disabilities



Source: (Canadian Council on Social Development, 2003); original source from Statistics Canada Census 1996 with custom tabulation for Canadian Council on Social Development.

Note: In this table, Aboriginal refers to those persons who identified themselves with being North American Indian, Métis or Inuit. Visible minority persons are defined under the Employment Equity Act (1986) as those (other than Aboriginal persons)

who are non-Caucasian in race or non-white in colour. Persons with disabilities are identified based on their responses to questions regarding their activity limitations or disabilities.

While the statistics on poverty among Aboriginal children are shocking, the real concern behind the numbers is the impact of this state of being on the health of Aboriginal Peoples now and in the future. This is because, “[p]overty rates are indicators of the health of citizens and the state of institutes. As well, poverty rates are predictors of long-term health issues in children” (Ontario Federation of Indian Friendship Centres, 2004). No matter how you look at the numbers, then, one can conclude that the current and future health of Aboriginal children is at serious risk.

5.2.1 The impact of child poverty on adult health

It is logical to assume that an adult’s socioeconomic status is associated with their socioeconomic status as a child. But since not all adults with low socioeconomic status grew up in poor socioeconomic conditions (and vice versa), understanding the patterns of socioeconomic status throughout the life course is needed to elucidate its association with an individual’s health status.

It is now well accepted that childhood origins can shape adult health through material deprivation and their influence on adult circumstances and behaviour, there is increasing evidence that childhood circumstances also affect developmental health, particularly through the activation of stress response systems (Boyce & Keating, 2004). As has been highlighted by McEwen and colleagues, recurrent stress responses triggered in early life by adverse social environments can initiate enduring physiological changes, such as alterations in lipid metabolism and the accumulation of body fat, the development of hypertension, and the development of insulin resistance that leads to Type 2 diabetes mellitus and CVD (McEwen, 2006). Several other studies have demonstrated the link between poverty in childhood and chronic diseases later in life (Cohen & Reutter, 2007; Everson, Maty, Lynch, & Kaplan, 2002; Galobardes, Lynch, & Davey Smith, 2004; Lawlor & Smith, 2005; Poulton et al., 2002; Power et al., 2007). In a Norwegian study, the highest risk of mortality among men and women was observed in the group that was poor both in childhood and in adulthood; this demonstrates a clear cumulative influence of social circumstances across the life course on mortality risk (Claussen, Davey Smith, & Thelle, 2003). In the same study, cardiovascular mortality was more strongly associated with childhood than with adulthood social circumstances. Thus, the latent effects of poverty on adult health show that the gradient of health begins to emerge in childhood (Graham & Power, 2004; Moody-Ayers, Lindquist, Sen, & Covinsky, 2007; Poulton et al., 2002). This is largely considered to be due to a number of intersecting factors including, but not limited to, poor nutrition and access to health care (Graham & Power, 2004). Further, the patterning of behaviour and lifestyle habits, which occurs in childhood, is thought to have a profound effect on future health and development.

5.2.2 Hunger and food security

Deeply connected with poverty is deprivation of nutrients and/or one’s inability to access, buy, and consume an adequate amount of food with sufficient nutrients. It is not surprising, then, that the most pressing concern of Aboriginal children living in poverty is a lack of food. In fact, the Canadian Council on Social Development has found that Aboriginal children are four times more likely to be hungry than any other ethnic minority in Canada (Anderson, 2003; McIntyre, 2003). Understanding what this means for the health of children living in poverty requires that review

the meaning of malnutrition and its impact on health.

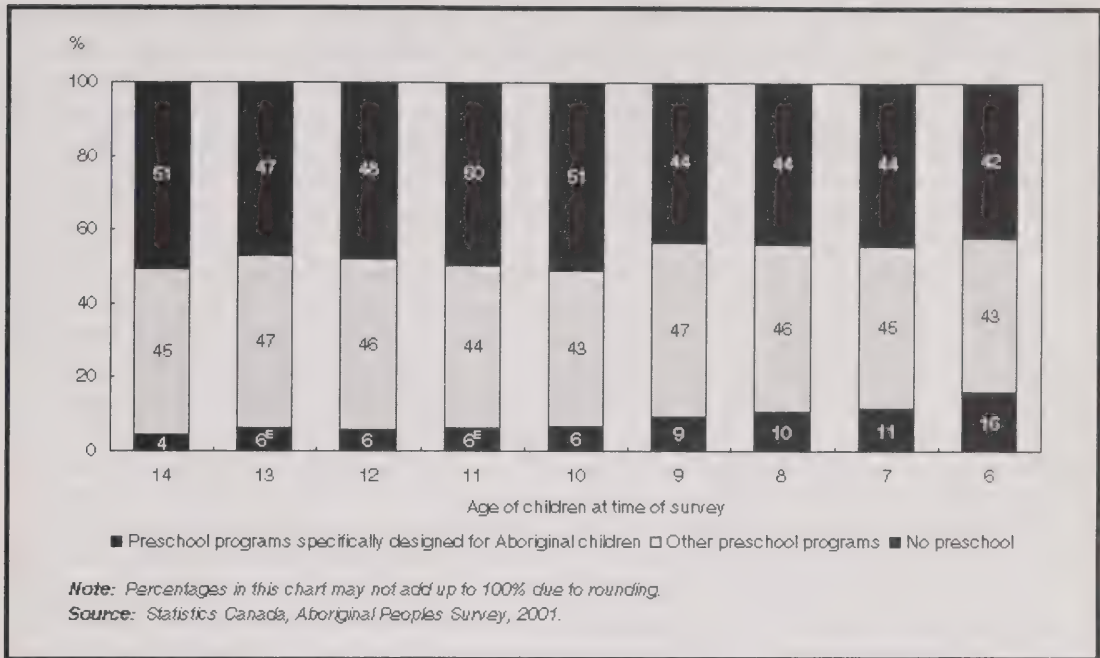
According to McIntyre (2003), “[m]alnutrition is defined as failure to achieve nutrient requirements, which can impair physical or mental health” (McIntyre, 2003). Thus, some common effects of poverty-induced malnutrition on health are mental, while others are physical (Ontario Federation of Indian Friendship Centres, 2004). For instance, a child’s ability to concentrate in school has been linked to food consumption; particularly kids’ access to breakfast. Stunted growth or low height for age, arguably the most accurate measures of malnutrition, demonstrate the more physical aspects of inadequate food consumption (McIntyre-food security, policy options). An additional concern with malnutrition is the consumption and absorption of important micronutrients, such as iron, iodine, and vitamin A (McIntyre, 2003). While the term malnutrition is a useful and effective word for describing hunger in developing countries, it has been argued that food insecurity is a better term to use when describing hunger in developed societies, such as Canada. Food security is defined by McIntyre (2003) as: “the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so”. Whether described as food insecurity or malnutrition, the ability for one to meet adequate nutritional levels consistently and completely is a key determinant of health (Ontario Federation of Indian Friendship Centres, 2004).

While the particular impacts of child hunger on long term health and development are complex and interact with the experiences of low socio-economic status that often predispose children to hunger, it is important to keep in mind that “child hunger is the extreme manifestation of household food insecurity” (McIntyre, 2003). Thus, a community perspective is useful.

Early child learning and development

In addition to physical growth and development, a lot of intellectual and social development occurs in the early years. This cognitive and social growth is often facilitated through family and community activities as well as participation and attendance in high quality early childhood development or preschool programs (Palacio-Quintin, 2000; Statistics Canada, 2001). According to the 2001 Aboriginal Peoples Survey (APS), just over half (53%) of Aboriginal children aged 6 to 14 living in non-reserve areas had attended an early childhood development program when they were younger (Statistics Canada, 2001). Inuit children were less likely to have attended a preschool program (35%) compared to First Nations (54%) and Métis (57%) children. Programs specifically designed to meet the needs of Aboriginal children, however, are increasing and these seem to have greatly increased enrollment and retention rates in early child development programs: “among the 14-year-olds, only 4% had attended preschool programs specifically designed for Aboriginal children when they were preschoolers. At the time of survey in 2001, 16% of six-year-old Aboriginal children in non-reserve areas had attended preschool programs specifically designed for them” (Statistics Canada, 2001). As these statistics show, Aboriginal children’s attendance at preschool is greatly distributed – both in terms of year they were born and Aboriginal ancestry. This is demonstrated in the figure below.

Figure 6. Aboriginal children in non-reserve areas who ever attended preschool programs, Canada, 2001



Source: (Statistics Canada, 2001)

The figure above, which is posted on Statistics Canada's website (Statistics Canada, 2001) shows that there has been a four-fold increase over eight years in the proportion of Aboriginal children in non-reserve areas attending preschool programs designed for them. Despite these gains, the absolute numbers remain low: "while one in two Aboriginal children in non-reserve areas attended preschool programs, only one in six attended programs specifically designed for them" (Statistics Canada, 2001). Since there was no statistically significant change over the number of Aboriginal children attending general preschool programs (i.e. not Aboriginal-specific programs), there is reason to believe that the potential for growth and development in this area comes through tailored programming. The hope is that such programs will encourage greater participation in early childhood education and allow children to gain important social and intellectual skills – both of which are integral for ensuring their long-term well-being and functioning in the world. It is also believed that such programs will prepare children for school later readiness and reduce drop out rates among Aboriginal high school students. In fact, many authors (Cairns, Cairns, & Neckerman, 1989) have shown that dropout rates are linked to a child's first five years at school. This further highlights that education and learning, especially in an individual's early years, are crucial to individual success and community prosperity (Cardinal, 2004).

5.4 Parental Smoking and Household Smoke

As has been discussed earlier, environmental factors can influence one's risk for chronic diseases at all life stages. It is important to note, however, that certain groups are more vulnerable to household environments. Children are one such group: children both spend more time indoors and are exposed to the household during their development, which in turn magnifies the impact of household environmental exposures. This is because long-term exposures to environmental risk factors can have harmful effects on growth, development, and function later in life (Sin, Sharpe, Cowie, & Man, 2004). This section will review, the impact of traditional and non-traditional tobacco use, as well as coal and wood-burning stoves.

Tobacco use is often discussed in terms of individual habits and practices. As such, it is often forgotten that the habits and practices of parents and other caregivers can impact their child health and development after infancy. While the prevalence and impact of smoking on the actual individual is discussed in the adulthood and adolescent sections, the focus here, is the impact of second-hand smoke on children. It is well documented that habitual smoking and passive smoking are significant problems in many Aboriginal communities. As a result, studies have found that many Aboriginal children live in homes where one or both of the parents smoke. This is particularly common for children with respiratory and other chronic ailments. For example, a study of First Nations children, 73% of those reporting airway obstruction lived in a home where one or both of the parents smoked (Orr et al., 2001). High parental smoking rates were also documented in a 1995-96 study of bronchiolitis among Inuit children: parental smoking occurred in 42 households (48.8%) of the 86 children studied and parents reported smoking within the vicinity of the house in another 31 households; parents in only three households claimed to be non-smokers (Mann, Wadsworth, & Colley, 1992). It is not surprising, therefore, that the literature also demonstrates that smoking exacerbates early life risks for chronic respiratory diseases (Millar, 1992; Sin et al., 2002). The physiological reasoning behind this is that smoke causes damage to the respiratory system that encourages or progresses the development of chronic respiratory problems (Alwyn, 2004). As the effects of smoking accumulates over the life course, exposure to smoke at a young age causes great risk for the development of chronic diseases associated with smoking, such as diabetes, cardiovascular diseases, and respiratory conditions, later in life. As such, the living environment and conditions that children are exposed to, through their parents' lifestyle choices and their home environments are important to consider. The influence of household smoke is briefly discussed below.

Another potential contribution to household smoke, other than direct parental or household members' smoking is enhanced by the continued use of coal and/or wood-burning stoves for heating, hot water, and cooking combined with the poor structure of many Aboriginal homes, outdoor smoke to enter the home (Cardinal, 2004; Petersen et al., 2003). Like passive smoke, household smoke can greatly aggravate the pulmonary system and interrupt normal breathing patterns or the growth, development, and function of the lungs and other organs of the pulmonary system (Harris et al., 1998). Further the association between poor air quality, the use of wood-burning stoves, poor housing conditions, and poor child respiratory health in many Aboriginal communities cause reason for concern (Chronic Disease Prevention Alliance of Canada, 2006).

6. Childhood and Adolescent Risk Factors

While the early stages of development in childhood are important to consider with regards to one's health and well-being throughout life, so too is the health of an individual throughout their childhood and into adolescence. And just like early childhood represents an important stage of development and growth, so do the physical developments (sexual and body changes) that occur during adolescence. Furthermore, the important psychological and social changes that occur alongside the physical changes mark this period as a critical stage towards becoming an adult. As some key risk factors, such as obesity, smoking and physical inactivity continue to be far higher among Aboriginal children and youth than the Canadian national average (Guo, Roche, Chumlea, Gardner, & Siervogel, 1994; Serdula et al., 1993), the health of this cohort is integral to consider from a life course perspective.

6.1 Childhood Obesity

Longitudinal studies among non-Aboriginal people have shown that being overweight or obese during childhood and adolescence is linked with childhood diabetes and predicts adult obesity (Barrett-Connor, 1989), which is associated with Type 2 diabetes (Hubert, Feinleib, McNamara, & Castelli, 1983) and coronary heart disease (Kumanyika, 1993). While high rates of pediatric obesity have been reported in studies of several racial groups (Bernard, Lavalley, Gray-Donald, & Delisle, 1995), Aboriginal children have been found to have a particularly high rates (Tjepkema, 2002): several studies have shown that Aboriginal children weigh (on average) more than other Canadians (Young, Dean, Flett, & Wood-Steiman, 2000). In a study of First Nations children aged 4 to 19, alarming obesity prevalence rates were documented: 64% of female children and 60% of male children were reported as being obese. In this study, obese children were shown to have an increased risk for diabetes (MacMillan et al., 1996). It is crucial to note here, however, that in Aboriginal arctic children, BMI should be interpreted with caution, because these children display a different pattern of growth with a high-weight-for-height pattern needed to survive in the climate they live in (MacMillan *et al.*, 1996). This different pattern of growth should not be confused with obesity (Reilly et al., 2005).

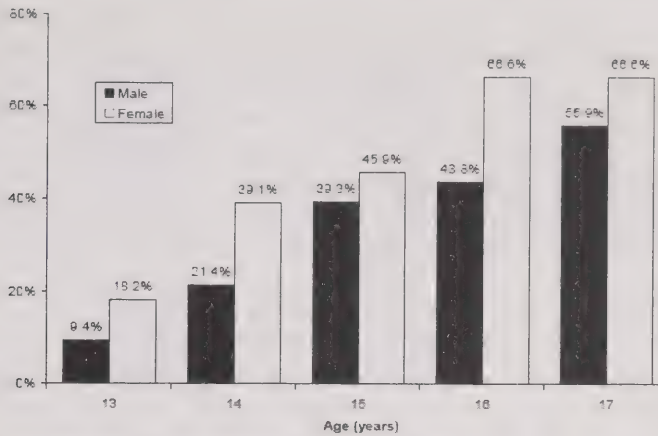
In order to understand the etiogoly of Aboriginal childhood obesity it is important to examine what are the root causes discussed in the Aboriginal and non-Aboriginal literature. An English longitudinal study conducted by Reilly et al (2005) carefully examined early life risk factors for childhood obesity. In addition to the already mentioned associations of childhood obesity with high birth weight and parental obesity (see prenatal section), researchers found that children who watched television for more than 8 hours a week were at an increased risk of being obese (Reilly *et al.*, 2005). Sleep duration was also independently associated with childhood obesity: children in the lowest two quarters of sleep duration (10.5 hours and 10.5-10.9 hours) at 30 months were more likely to be obese at age 7 than children in the highest quarter (> 12 hours). The reasoning behind this correlation is that while television viewing reduces energy expenditure, sleep duration alters growth hormone secretion, changes a child's exposure to obesity-promoting factors, such as evening food intake, and acts as a marker for adequate physical activity levels (Hanley *et al.*, 2000).

A study undertaken in the Sandy Lake First Nations community also examined the correlation between obesity and television viewing (Hanley *et al.*, 2000). This study found that children who watched more than five hours of television per day were associated with a 2.5-fold increase in the risk of becoming (or being) overweight, when compared to children who watched less than 2 hours of television per day (Hanley *et al.*, 2000). In the same study, children with higher fitness levels and greater fiber intake were found to be less likely to be overweight (First Nations Information Governance Committee., First Nations and Inuit Regional Health Survey National Steering Committee., First Nations Centre., & National Aboriginal Health Organization., 2004). According to the 1997 First Nations and Inuit Regional Health Survey, 98 per cent of children watched television each week for an average of 2.9 hours each day (Bernard *et al.*, 1995; Ng, Marshall, & Willows, 2006). Other Aboriginal studies have found that overweight Cree schoolchildren and adolescents participated in significantly less physical activity and consumed significantly fewer servings of fruits and vegetables than did their normal weight peers (First Nations Information Governance Committee. *et al.*, 2004). When asked by the RHS about the availability of sports and cultural facilities in their community, fewer than half of Ontario Aboriginal youth reported having sports facilities. The most commonly cited needs were for a community swimming pool, followed by playground equipment, arena and drop-in centres (Ritchie & Reading, 2004). As issues of obesity in Aboriginal communities across the nation relate to an increasingly sedentary lifestyle, a lack of exercise, and poor nutrition, these underlying predictors of obesity should be better understood and targeted for prevention. Such intervention is important because it is likely that reductions in pediatric obesity will enable substantial positive health changes later in life.

6.2 Smoking

Even though smoking rates have declined among Aboriginal Peoples in recent years, Aboriginal smoking rates are still higher than those in Canada's general population (Chronic Disease Prevention Alliance of Canada, 2006); (Ritchie & Reading, 2004). A significant concern, however, are the high rates of smoking among Aboriginal children and youth (Canada, 2003).

A major concern with Aboriginal youth smoking is that they are smoking at much higher rates than their Canadian counterparts. For Canadian youth, the prevalence of smoking, was found to be 18% for 15-19 years olds and 30 % for young adults aged 20-24, with higher rates for female smokers (2002/2003). Comparatively, the prevalence of tobacco smoking among Aboriginal youth, reported by the Aboriginal Peoples Survey (2002/03), was 54% among 15–19 year olds and 65% among 20–24 year olds. Inuit youth were more likely to smoke (73% in the 15–24 age group) compared to the Métis or First Nations youth (56% and 59% respectively in the 15–24 age group). The distribution of smoking patterns among different age groups and genders is illustrated in Figure 3.1 below.

Figure 7. The Distribution of Smoking Patterns Among Different Ages (n=2,494)

*Percentage for age 12 is suppressed due to small sample size.

Source: Adapted from RHS 2002/2003 (First Nations Information Governance Committee, et al., 2004)

High rates of smoking among Aboriginal teenagers are of particular concern for the future health of the Aboriginal population because they represent the largest demographic group within the Aboriginal population and because they represent the future of this population. Particularly high rates of smoking among females suggest the need to target this group and understand the particular causes associated with this gender difference.

In addition to high prevalence rates, Aboriginal smokers have been found to initiate smoking at an earlier. According to reports by parents in Manitoba, 19% of all Aboriginal children under the age of 18 smoke (Ritchie & Reading, 2004) and the peak age for starting smoking was 16, with many Aboriginals beginning as young as 11. A survey conducted at the 2002 North American Indigenous Games found that Aboriginal youth reported an average age of 12.2 years for smoking initiation, with the youngest reported age being 4 years old (Ritchie & Reading, 2004). By the age of 6, about 2% of Aboriginal children had initiated smoking, which doubled by the age of 8, and then doubled again by the age of 12, peaking at the age of 13 (Mann et al., 1992). Overall, the research shows that Aboriginal children today start smoking at a very young age.

Beginning smoking at such a young age means that these children have virtually an entire lifetime to accumulate risks for chronic diseases associated with smoke-related environments and activities. It is well-documented that smoking exacerbates early life risks for respiratory diseases by damaging the respiratory system and encouraging or progressing the development of chronic respiratory problems (Cunningham, Dockery, Gold, & Speizer, 1995). Throughout childhood and later in life, exposure to smoke can continue to reduce lung function and increase the risk of respiratory problems (Retnakaran, Hanley, Connelly, Harris, & Zinman, 2005). The consistently high rates of smoking among Aboriginal youth also raise concerns about the long-term risks of developing chronic conditions. A study of the Sandy Lake First Nation, which reported that 82% of participants between the ages of 15 and 19 currently smoked (Ellickson, 2001), found a strong association between current smoking exposure and cardiovascular risk factors. This means that

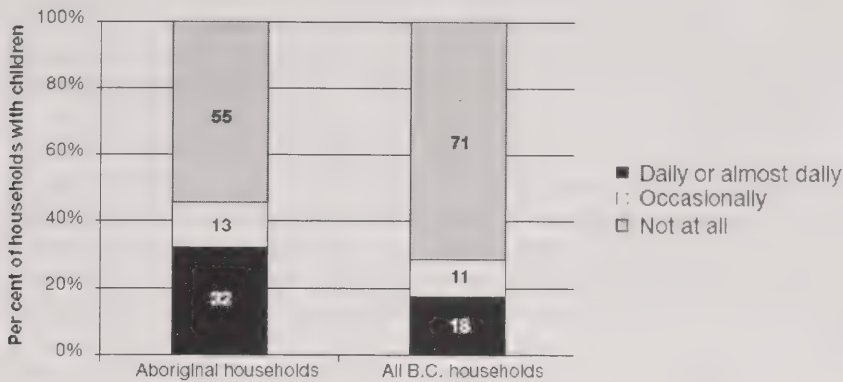
both immediate and long-term implications are an issue for this population.

Research shows, however, that smoking also affects one's mental health. A longitudinal, five-year follow-up study has found a statistically significant ($p = 0.05$) association between early smoking and high-risk behaviours in grade-seven adolescents (Ellickson, 2001): compared with non-smokers, early smokers were 82 times more likely to engage in weekly marijuana use and 36 times more likely to engage in hard drug use; 11 times more likely to engage in weekly drinking and 8 times more likely to engage in binge drinking; 7 times more likely to steal. These adolescents were also at higher risk for low academic achievement and behavioural problems at school and use of predatory and relational violence (First Nations Centre, 2005).

Despite the overwhelmingly negative statistics reported in the literature on Aboriginal youth smoking, there are also positive statistics regarding the smoking practices of this population. For example, the 2002/03 RHS reported that Aboriginal youth smoke significantly less cigarettes a day than Canadian youth in the fifth to nine grades age group (5.9 vs. 8.1 cigarettes a day) (First Nations Centre, 2005). A cross-sectional, opportunistic study conducted at the Winnipeg 2002 North American Indigenous Games in Canada, found the prevalence of tobacco smoking in the studied cohort of 570 Aboriginal youth between ages 12 to 22 years old was 32% (Ritchie & Reading, 2004). A follow-up study conducted at the Cowichan 2008 North American Indigenous Games, measured an even lower rate of smoking in Aboriginal youth: only 6.3% of youth were currently smokers (Kelly, Link, & Reading, 2009). This lower prevalence rate suggests that because the participants were attending or competing at a sports event they may be more health conscious than other Aboriginal youth and, therefore, may be less likely to develop unhealthy lifestyle behaviours (British Columbia, 2001). As such, more participation in sport or other health activities may be an effective way to improve smoking rates in Aboriginal communities. Finally, a 3 % reduction in smoking rates among First Nations adults living in Canada from 1997-2001 (First Nations and Inuit Regional Health Survey National Steering Committee, 1999; First Nations Centre, 2005) is encouraging for the future. The hope is that declines in smoking rates among adults will continue and will also influence lower smoking rates among children and youth through positive role modelling. At the very least, however, Aboriginal children and youth will be exposed to less passive smoke.

Issues related to passive smoking are important to consider for this age group, just as they are for infants and throughout early childhood (see natal and early childhood sections for "parental smoking"). According to the Tobacco Use in British Columbia 1997 survey, 32% of Aboriginal children were daily or nearly daily exposed to cigarette smoking in their homes (British Columbia, 2001). This compares to 18 % of all BC households with children exposed to smoking (British Columbia, 2001). The data from this survey is summarized in the Figure 7 below.

Figure 8. Exposure to Second-Hand Smoke Households with Children Age 11 and Under, BC, 1997



Source: (Orr et al., 2001)

As noted earlier, extremely high parental smoking rates have been documented in studies of Inuit children: parental smoking occurred in 48.8% of the homes and parents reported smoking within the vicinity of 36% of the households; parents in only 3.4% of the households claimed to be non-smokers (Koch et al., 2003). Although the correlation between passive smoking and chronic disease development is not as clear as personal smoking behaviours, it has been found that passive smoking can complicate respiratory and other health problems and foster the development of chronic conditions (Weitzman *et al.*, 2005). The varied influence of exposure to tobacco smoke on chronic disease is demonstrated by a study of 2273 American adolescents (Weitzman *et al.*, 2005). This study specifically examined the connection between smoking and metabolic syndrome. Out of the study population, 5.6% of the adolescents met the criteria for metabolic syndrome. However, the prevalence for metabolic syndrome was 1.2% for those not exposed to tobacco smoke, 5.4% for those exposed to environmental tobacco smoke, and 8.7% for active smokers (First Nations Centre, 2005).

6.3 Sexual Health

According to Regional Health Survey 2002-03, First Nations youth are more sexually active than their Canadian counterparts (First Nations Centre, 2005). Considering that “the levels of alcohol and drug abuse among First Nations youth are [also] higher than those in mainstream society”, it can be posited that First Nations youth could be at an increased risk of unprotected sexual activity and, therefore, sexually transmitted infections (Gray, 2005). The sexual health of Aboriginal youth is also related to the trends of cancer development. This is because it has been documented that women who have multiple sexual partners or who become sexually active at an early age are more likely to develop cervical cancer (Gray, 2005). The reason early sexual activity is linked to cancer risk is because during puberty cervical tissue undergoes many changes that might make the area more vulnerable to damage (Gray, 2005). There is also a suspected connection between STD’s and cervical cancer: “[i]nfection with human papillomavirus (HPV) increases your risk 20 to 100 times” (Gray, 2005). While HPV is a quite common sexually transmitted virus, there are over 100 types of HPV and only a few that are the

high-risk types that will influence the risk of cervical cancer (Gray, 2005; NAHO, 2004; PapScreen Victoria, 2006). Nonetheless, sexual activity increases the risk of getting HPV and, in particular, high-risk types of HPV and, therefore, must be treated with caution and concern. While pap tests have been shown to dramatically reduce the number of women who die from cervical cancer, traditionally low rates of pap smear testing among Aboriginal women remains a concern for early detection and cancer survival in this population (Ontario Federation of Indian Friendship Centres, 2004).

Because of particular vulnerabilities among Aboriginal youth, such as low socioeconomic status, disempowerment as a result of historical and cultural conditions, and lack of education, sexual exploitation is also a concern for this population's sexual health and well-being. Save the Children Canada's National Aboriginal Project recently released a report on the nature and depth of commercial sexual exploitation of Aboriginal children and youth across Canada. The study found that:

“the rate of commercial exploitation of Aboriginal children and youth has reached levels of more than 90% in some communities where the Aboriginal population is less than 10%;

the serious over-representation of Aboriginal youth in the sex trade is directly linked to the unacceptably high level of risk factors which Aboriginal children and youth face, including alarmingly high poverty rates”

(Ontario Federation of Indian Friendship Centres, 2004).

As described by the report, the reality of the disproportionately high rate of Aboriginal children and youth living in the sex trade is perpetuated by pressures related to poverty and low socio-economic status common within this group (Chansonneuve, 2005; Indian Residential Schools Resolution Canada [IRSRC], n.d.). In addition to economic reasons, cultural and historical factors are essential to understanding the experiences of children and youth. In particular, the experiences of parents that are inherited by their children have been shown to have a lasting impact on the sexual health practices of Aboriginal children and youth. The particular impacts of the historic and current education system on the learned and experienced history of Aboriginal children and youth are discussed in greater detail below.

6.4 Education

The education system, past and present, is an integral aspect of the lives of Aboriginal children and youth. Looking to the past first, this section will discuss the legacy of the residential school and its ongoing impacts on health. Next, the experiences of Aboriginal Peoples in the current school system and their impacts on health will be discussed.

6.4.1 Residential Schools

Education of Indians became a responsibility of the federal government in 1867 under the British North America Act (Chansonneuve, 2005; Fournier & Crey, 1997). By this time, Indian day schools had been established, but the government was urged by the Davin report of 1879 to establish residential schools instead: Davin believed residential schools to be the most effective means of assimilating Indian children. In 1892, the Canadian government established

partnerships with Roman Catholic, Anglican, Presbyterian and Methodist churches to run the operation of Indian residential schools. Except in the provinces of Newfoundland, Prince Edward Island, and New Brunswick, residential schools were established across the country (Fournier & Crey, 1997; Indian Residential Schools Resolution Canada [IRSRC], n.d.). Attendance increased after 1920, when an amendment to the Indian Act made education of Indian children between the ages of 7 and 15 years old mandatory for ten months of the year (Fournier & Crey, 1997). Nearly three-quarters of Indian children across Canada attended residential school by 1930. The number of schools peaked in 1931 when over eighty schools were operating (Indian Residential Schools Resolution Canada [IRSRC], n.d.). Some Aboriginal children began attending provincially-run public day schools in the 1950s, and by 1969, when the federal government took full control over residential schools, 60% of Aboriginal students attended public day schools (Fournier & Crey, 1997). From the inception of residential schools in the 1800s to the closure of most of the schools in the 1970s, almost one-third of Aboriginal children spent a large portion of their childhood in attendance at residential school (Beauchamp et al., 2004; Chansonneuve, 2005; Indian Residential Schools Resolution Canada [IRSRC], n.d.). The last federally run residential school closed in 1996 (Dion Stout & Harp, 2007). There are an estimated 86,000 residential school survivors alive today (Dion Stout & Kipling, 2003; King, 2006).

The residential school system was not exclusive to Indian children. The boarding, missionary, hostel and residential schools attended by Inuit children are also defined as part of the residential school system;¹⁰ further, Inuit children who lived away from home while attending federal day schools are considered residential school survivors (King, 2006). In some areas of the North, churches ran federally funded missionary schools until the federal government accepted responsibility of Inuit education (King, 2006). Education in the Arctic was controlled by the federal government between 1955 and 1970. Inuit student enrolment rose from a total of 549 in 1956 to 2,390 in 1963 (Chansonneuve, 2005). Less than 15% of Inuit children aged 6 to 15 years were enrolled in school in 1955, but by 1964, three-quarters (75%) were enrolled.

Métis children were also students of the residential school system. Exact enrolment numbers are difficult to determine because records of Métis students were not always kept (Chartrand, 2006). Although Métis education was not recognized as a federal responsibility, Métis children were occasionally allowed to enrol or enrolled in residential schools for a particular purpose (Chansonneuve, 2005; Chartrand, 2006; Logan, 2001), such as assimilation or to boost attendance records in order to receive more funding (Chansonneuve, 2005; Logan, 2001). Factors that influenced the likelihood of Métis admission to residential schools included proximity of schools to Métis communities, school denomination (as Métis had a stronger connection to the Roman Catholic Church), family history, and social standing (Logan, 2001). Métis children were more often admitted to residential school if their family had money to pay for schooling, if their physical features were characteristic of Indian attributes, or if their lifestyle was most associated with that of Indians and, therefore, seen to be in greater need of assimilation (Fournier & Crey, 1997; Kirmayer et al., 2003; Reading, 1999).

¹⁰ The residential school system in Canada has been defined to include “industrial schools, boarding school, homes for students, hostels, billets, residential schools, residential schools with a majority of day students or a combination of any of the above”.

Punishments and abuse were widespread and often severe in the residential school system. Children who expressed Aboriginal language and culture or sought contact with family were commonly administered harsh disciplines, which some scholars have even labelled as torture (Chrisjohn & Young, 1995). Such punishments exceeded the standard forms of discipline in Canadian public schools at the time and “the infractions which “warranted” this treatment were not infractions for any children in Canada save Aboriginal ones” (Chansonneuve, 2005). The abuse that occurred at residential schools included physical, sexual, emotional and spiritual abuse and has been described as ritualized, or “repeated, systematic, sadistic and humiliating trauma”(Chansonneuve, 2005; Chrisjohn & Young, 1995; Fournier & Crey, 1997; Kirmayer et al., 2003; Reading, 1999). Children were: under constant surveillance, continually underfed and malnourished, humiliated in front of peers, degraded for their Aboriginal culture and heritage, deprived of gifts and letters from family, denied emotional comfort, forced to perform hard labour, and forced to witness the abuse of other children (1997). Fournier and Crey (1997) stated that student deaths due to abuse and neglect were concealed, but had the schools been held accountable, they would be guilty of “criminal negligence, manslaughter and even murder” ([IRSRC], n.d.; Beauchamp et al., 2004). In the 1990s, apologies were issued from the Catholic, Anglican, United and Presbyterian churches as well as the Canadian government for the physical and sexual abuses that occurred in residential schools (Corrado & Cohen, 2003; Waldram, Herring, & Young, 2006). In June 2008, an apology was finally issued by the Canadian Government (Harper, 2008).

In addition to the multitude of abuses experienced in residential schools, children endured atrocious living conditions. Low government funding contributed to the poor nutritional value of food and lack of medical services available to students (Fournier & Crey, 1997). Dormitories of the schools were often overcrowded and unventilated (Corrado & Cohen, 2003; Fournier & Crey, 1997; Waldram et al., 2006). As a result of the poor living conditions, illness and diseases such as tuberculosis raged through residential schools (Chrisjohn & Young, 1995; Fournier & Crey, 1997).

The goal of the residential school system to assimilate, rather than educate, Indian children is demonstrated by the poor quality of education provided. Only half of the day at school was devoted to academic instruction, while the rest of the day was spent in teaching children religious ideology or forcing children to contribute to school maintenance and other labour-intensive projects (Fournier & Crey, 1997). In 1930, at the height of residential school operations, three-quarters (75%) of Indian students were below third grade level (compared to less than half of the children in provincial public schools), and only 3% of Indian students achieved higher than a sixth grade education (compared to one-third of children in provincial public schools) (Reading, 1999). The inadequate education provided by residential schools left former students with few skills to function in mainstream society and may have adversely affected their future quality of life (Chartrand, 2006; King, 2006; Logan, 2001).

Experiences of Métis and Inuit children who attended residential schools were often similar to those of Indian children. Stories of neglect, poor living conditions, fierce punishments, cultural suppression and physical and sexual abuse have been told by Métis and Inuit residential school survivors (Logan, 2001). Some Métis students adjusted more easily to residential school life because of their greater familiarity with Catholicism and the English or French languages

(Chartrand, 2006; Logan, 2001). Other Métis children felt they were treated as “second class” students because the federal government did not provide funding to churches for education of the Métis and they were considered neither full-blooded Indians with recognized rights, nor full-blooded Caucasians of dominant society (Anderson, 2003).

The residential school system is a dark chapter in the history of Canada’s treatment of Aboriginal Peoples and their educational history. What it does so effectively highlight, however, is the great impact that educational settings can have on children, parents, grandparents, and, indeed, generations. As we look to the current educational system, it will be important to remember the history of the residential school system, as well as the close connection that education has on the economic and social success of all Canadians.

6.4.2 The Current Education System

In general, data shows that the attendance of Aboriginal youth in schools is lower than non-Aboriginal youth. For instance, data from 1996 shows that “68% of Aboriginal youth were in school compared to 83% of non-Aboriginal youth” (Statistics Canada, 2001). School completion has also been shown to be lower: in 1996 as well, just over half (52%) of the Aboriginal population aged 20 to 24 living in non-reserve areas had not completed secondary school. By 2001, this proportion had dropped to 48% (Statistics Canada, 2001). Nevertheless, there was still a huge gap between the Aboriginal population and the general Canadian population: in 2001, only 26% of the general population aged 20 to 24 had not completed secondary school (Statistics Canada, 2001).

The proportion of secondary school graduates is an important predictor of future education and employment rates. Some important information on Aboriginal post-secondary enrolment and completion rates is included in a report completed by the Millennium Scholarship Foundation in 2004, titled “Aboriginal Peoples and Post-Secondary Education: What Educators have learned.” Some of its key points are reviewed in the following paragraph.

As noted by the Millennium Scholarship Foundation, post-secondary enrolment and completion rates for Aboriginal people have been steadily increasing over the past two decades. Despite these increases, however, the rates for Aboriginal Peoples remain significantly lower than those of non-Aboriginal Canadians (Malatest, 2004). For instance, the 1996 Census found that:

“Three per cent of registered Indians and four per cent of other Aboriginal identity groups had obtained university degrees, compared with 14 per cent of all other Canadians. The percentage of registered Indians with some post-secondary education was 37 per cent—for all other Aboriginal identity groups it was 47 per cent, significantly lower than the rate for all other Canadians at 51 per cent” (Malatest, 2004).

While the increasing number of Aboriginal graduates is encouraging, it is important to remember that there are still many limitations and barriers to Aboriginal youth’s educational achievements. The following quote outlines some of these limitations and barriers:

“While socio-economic factors such as poverty and unemployment put them at an obvious disadvantage, Aboriginal students also face more subtle barriers such as discrimination, low self-concept and institutional insensitivity to Aboriginal cultures.

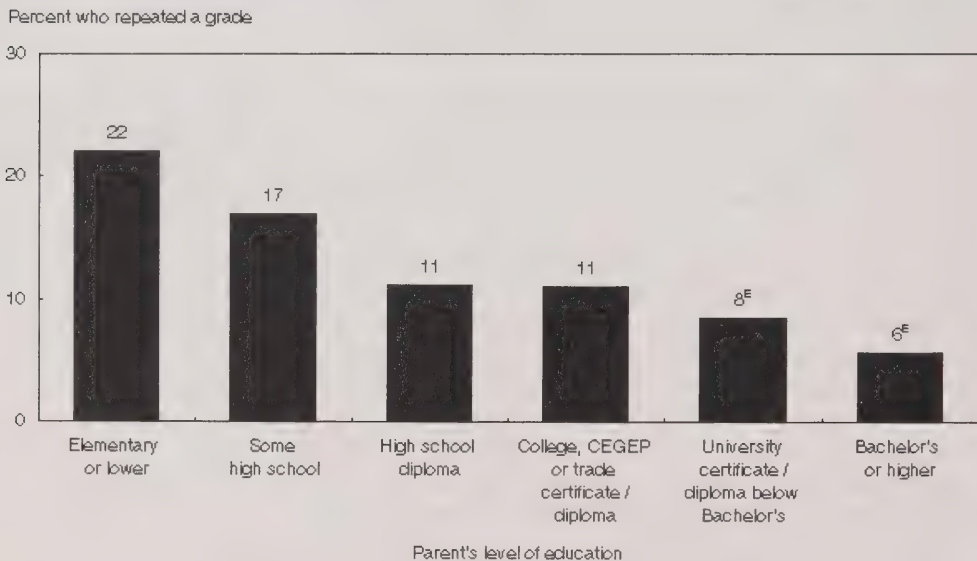
Many Aboriginal students arrive in post-secondary institutions without adequate high school preparation; others struggle to balance education with family responsibilities. Combined with a history of forced assimilation through educational institutions, the barriers to Aboriginal participation in post-secondary education are formidable”
(Malatest, 2004).

Thus, post-secondary education must take into account the social, cultural or economic needs of Aboriginal peoples (Malatest, 2004).

These challenges and barriers, as well as the raw numbers on Aboriginal education, are important to take into account, as the importance and value of a formal secondary and post-secondary education is only increasing with time: “With the advent of the knowledge-based economy, jobs are becoming increasingly scarce for individuals without a diploma or a degree from a high school, college or university” (Statistics Canada, 2001). Statistics Canada (2001) found that differences in unemployment rates among Aboriginal Peoples could be partially attributed to educational backgrounds. This means that education can predict the employability of a person and, therefore, also their future socioeconomic status.

Research has also found that education rates among Aboriginal children and youth is closely related to their parents’ education levels (Statistics Canada, 2001). For instance, De Broucker and Lavallée (1998) have reported that the higher parental education levels, the higher the education levels of their children. This association is demonstrated in the figure below, which shows that parental education is a factor in Aboriginal children’s likelihood of repeating a grade.

Figure 9. Percentage of non-reserve Aboriginal children repeating a grade



Source: Statistics Canada, Aboriginal Peoples Survey, 2001.

The figure shows that as the parent's education level increases, the proportion of children having ever repeated a grade decreases. That is, for parents who had not gone beyond elementary school, 1/5 of their children had repeated a grade, whereas only 6% of children of parents with a bachelor's degree or higher had repeated a grade at some point in their life. Some reasons given for the correlation between child and parent education include: (1) parents with higher levels of educational attainment will take greater interest in their child's education and, therefore, encourage learning activities and homework (Stevenson & Baker, 1987) and (2) highly educated parents tend to have higher academic expectations for their children, which has shown to greatly influence the success of a child in school (Astone & McClanahan, 1991; Hull, Research, Analysis, & Indian and Northern Affairs, 2000; Teachman, 1987; Teachman & Paasch, 1998). In addition to parental influences, the extended family, Elders and the community play key roles in childhood education and learning in Aboriginal populations. This is because learning in Aboriginal communities includes both cognitive development and learning how to behave in society (Smith et al., 1997). This suggests that the educational levels and supports provided by the community and the extended family are all important for childhood growth and development.

In addition to parental and family educational levels and support, the success of children in school has also been linked to their family's household income. That is, many studies have shown that children from economically disadvantaged families experience greater difficulties learning and have more problems in school (Chao & Willms, 2002; Duncan & Brooks-Gunn, 1997; Petterson & Albers, 2001; Ross & Roberts, 2000; Smith & Klebanov, 1997; Statistics Canada, 2001). Statistics showing education levels in Aboriginal children living in non-reserve areas verifies this understanding: "About 16% of children in families with income below the low income cut-off had repeated a school year at some point, compared with only 10% of children in families at or above the low income cut-off" (Bennett, Blackstock, & De La Ronde, 2005; Canada, 2006; Fournier & Crey, 1997; Gough, Trochmé, Brown, Knoke, & Blackstock, 2005; Kirmayer et al., 2003; Sinclair, 2007).

6.5 Aboriginal Child Welfare

In the 1960s, when an increasing number of Aboriginal children were being enrolled in provincial public schools rather than federally funded residential schools, a new assault on Aboriginal families emerged. Termed as the 'Sixties Scoop', this assault was propagated through a disproportionately high number of Aboriginal children being taken from their families and communities to be placed in out-of-home care (Fournier & Crey, 1997). Aboriginal children, who made up less than 4% of the Canadian population and who represented only 1% of children in care in 1959, suddenly represented 30-40% of children in care at the end of the 1960s (Fournier & Crey, 1997; Sinclair, 2007). More often than not, Aboriginal children taken from their families were placed in non-Aboriginal homes (1996): the Royal Commission on Aboriginal Peoples (Fournier & Crey, 1997; Gough et al., 2005) reported that except in Quebec, the proportion of Aboriginal children in care placed in non-Aboriginal homes was 70 to 90% across provinces. Much like children who attended residential schools, Aboriginal children who became legal wards were separated from their parents, siblings, communities and cultural identity, often without the knowledge of where they came from and sometimes without their birth names (Bennett et al., 2005). Siblings were often placed in separate homes, partially due to the difficulty of finding homes to accommodate large Aboriginal families, but also with the goal

of better assimilating the children. Few children were ever returned to their home (Fournier & Crey, 1997).

Driven by the same paternalistic attitude that created the residential school system, the 'Sixties Scoop' was propelled forward with the belief that Aboriginal parents were unfit to raise their children (Canada, 2006). The poor parenting skills that stemmed from generations of Aboriginal children attending residential schools likely contributed to this belief (Bennett et al., 2005; Fournier & Crey, 1997). However, many children were taken from their homes for reasons Aboriginal parents had little control over; that is, poor socioeconomic status and simply being Aboriginal (Morris, 2007). Social workers, who were trained to uphold Eurocentric standards in child welfare, believed it in the best interest of the children to remove them from reserves stricken with poverty rather than provide support services to families and communities in need (Fournier & Crey, 1997; Kirmayer et al., 2003).

Although this process of removing Aboriginal children from their homes has been termed the 'Sixties Scoop', child welfare agencies have continued to remove Aboriginal children from their homes long after the 1960s (Fournier & Crey, 1997). By the end of the 1970s, at least one in three Aboriginal children had been involved in government care (Bennett et al., 2005). In 1983, Aboriginal children represented roughly 50% of children in care in Alberta, 60% in Manitoba, and 70% in Saskatchewan (Blackstock, Trochmé, & Bennett, 2004; Kirmayer et al., 2003). Today, Aboriginal children are still disproportionately represented among children in out-of-home care (Sinclair, 2007), and one university professor has suggested that the 'Sixties Scoops' has evolved into the "Millennium Scoop" (2004). Blackstock and colleagues (1997) estimate that when compared to the number of Aboriginal children in residential schools during years of peak enrolment, there are three times as many Aboriginal children in out-of-home care today. Fournier and Crey (1997) reported that in British Columbia, over half (52%) of children placed in care by court order each year are Aboriginal. Over three-quarters (78%) of Aboriginal children in permanent care in British Columbia are cared for in non-Aboriginal homes (Sinclair, 2007).

The outcomes for Aboriginal children raised in non-Aboriginal homes are not always negative, as some of those children have grown to find success and happiness in their careers, families and communities (Bennett et al., 2005; Carriere, 2007; Sinclair, 2007). However, many Aboriginal survivors of the child welfare system have shared stories of their struggle to establish a sense of identity among foster and adoptive families, birth families, Aboriginal communities and mainstream society (Bennett et al., 2005; Morris, 2007; Sinclair, 2007). These struggles have presented difficulties throughout their childhood and adolescence and sometimes into adulthood. The negative impacts on the mental health of Aboriginal children cared for in non-Aboriginal homes may include issues of identity formation, low self-esteem, feelings of shame, suicidal ideations and attempts, substance abuse, homelessness, and incarceration (Anderson, 2003). Not only have these mental health issues emerged as problems for the cohort of grown Aboriginal 'Sixties Scoop' survivors, but for the disproportionate number of Aboriginal children still a part of the child welfare system, they represent the potential for health problems of the near future.

An analysis of the child in care data from three sample provinces in May 2005 found that approximately one in 10 of all status First Nations children were in child welfare care, compared to one in 200 non-Aboriginal children (Blackstock, Prakash, Loxley, & Wien, 2005.) Year-end

data collected by the Department of Indian and Northern Affairs Canada indicates that the number of status First Nations children living on-reserve entering child welfare care increased a staggering 71.5 percent from 1995 to 2001 (McKenzie, 2002). The Canadian Incidence Study on Reported Child Abuse and Neglect (Trocmé, MacLaurin, Fallon, Daciuk, Billingsley, et al., 2001) found that neglect was the primary reason that First Nations children were coming into care at disproportionate rates. Controlling for poverty, substance use, and poor housing substantially accounted for the overrepresentation (Trocmé, Knoke, & Blackstock, 2004; Trocmé, MacLaurin, Fallon, Knoke et al., 2006).

The overrepresentation of First Nations children occurs at every phase of child welfare intervention from reports, investigation, substantiation, entry into care and placement in permanent child welfare care (Trocmé, MacLaurin, Fallon, Knoke et al., 2006; Blackstock, 2007). Preliminary analysis of child in care data from three provinces[1] and 27 First Nations child and family service agencies indicates that First Nations children also make up a disproportionate number of permanent wards in Canada (First Nations Child and Family Caring Society of Canada [FNCFCS], 2006). For example, Aboriginal children represent 7.3 percent of the child population in the Province of British Columbia (Statistics Canada, 2001) but 47.8 percent of all children in care as of May 2005 (British Columbia Ministry for Children and Family Development [BCMCFD], 2005). In Nova Scotia, First Nations children are 3 to 6 times more likely to be in child welfare care than non-Aboriginal children (Nova Scotia Department of Community Services, 2008). Moreover, Aboriginal children represent 53.5 percent of all children in permanent care in BC and 47.6 percent of all children in temporary custody (BCMFD, 2005). In 2005, a survey of 27 First Nations child and family service agencies across Canada (excluding Ontario) found that 47 percent of the children served were in permanent care (FNCFCS, 2006).

Poverty is a cross-cutting risk factor affecting spiritual, emotional, cognitive, and physical well-being of children, families, and communities (Loppie-Reading & Wien, 2009). For example, research has consistently pointed to children living in poverty as having poorer physical and mental health outcomes and less success in school (Gabrarino, 1995; Blackstock, Bruyere, & Moreau, 2007; Barth, 2006; Loppie-Reading & Wien, 2009) and being particularly related to the substantiation of neglect cases (Sealand, 2003; Lindsey, 2004; Trocmé et al., 2006). While it would be unreasonable to expect that child welfare can eradicate poverty on its own, child welfare has a minimal expectation of centering it in the child welfare discourse given the pervasive evidence of its impacts on child safety and wellbeing.

In child welfare, poverty can manifest as physical neglect or failure to supervise and be an aggravating factor for other forms of maltreatment (Lindsey, 2004; Trocmé et al., 2006). Provincial child welfare legislation, including the *Child and Family Services Act* in Nova Scotia, do not delineate between neglect resulting from poverty and neglect caused by parental negligence. This is a critical issue in First Nations communities where poverty is more widespread, and at deeper levels, than among non- Aboriginal Canadians.

7. Adulthood and the Elderly Risk Factors

As discussed in the previous sections, Canada's Aboriginal population is younger than the general population: "The median age of Canada's Aboriginal population was 24.7 years in 2001, compared to 37.7 years for Canada's non-Aboriginal population" (Canada, 2003). But, while adulthood does not command the population as much as the baby boomers do in Canada's non-Aboriginal population, their health needs and concerns are of equal importance. Further, as the life expectancy of Aboriginal Peoples continues to increase and as chronic health conditions begin to take precedence over communicable diseases, the health and well being of adults and elders will begin to take an even more important role in the profile of Aboriginal health. With this in mind, the particular risk factors associated with chronic diseases among Aboriginal adults, such as smoking, alcohol abuse, obesity, and employment and education, are discussed below. Finally, the unique aspects of elder health are discussed at the end of this section.

7.1 Smoking

As noted in the sections on maternal smoking, parental smoking, and smoking among Aboriginal children and youth, the Aboriginal population has higher rates of smoking than the non-Aboriginal population. In fact, the Aboriginal population in Canada has a much higher proportion of current cigarette smokers (58% vs. 31%), and fewer former (17% vs. 23%) or never smokers (24% vs. 45%) than the general population. According to Health Canada's 2005 Tobacco Report, almost 60 % of on-reserve First Nations adults aged 18-34 smoke. This can be compared with data from the Canadian Tobacco Use Monitoring Survey (CTUMS) which reported 21% of Canadian general population were smokers in 2003 (Canada, 2005). The smoking rates are even higher among Inuit in the north of Canada, where almost 70 % of adult population smoke tobacco (Canada, 2005). The 2002/03 Regional Health Survey documented similar smoking rates (58.8%) among First Nations adults (First Nations Centre, 2005).

What is important to add to these statistics is a discussion of the risks of chronic disease development associated with smoking. For instance, it has been estimated that smoking tobacco is responsible for about one third of all fatal cancers (Greenhalgh, 1981; Hausteine, 2003; Swales & De Bono, 1993). The relationship between smoking rates and cancer rates has been established by the research community and found to be proportionally related: in other words, the higher the smoking rate, the higher the rate of cancer. This is of concern for Aboriginal cancer rates, as statistics have already begun to show rising rates of previously non-existent cancers in Aboriginal populations. Smoking has also been linked to an increased risk of cardiovascular disease and diabetes (Sin et al., 2002), and a higher incidence and prevalence rates of COPD and asthma (Ghadirian, 2005)

The good news is that changes to smoking habits at any life stage can greatly reduce the risks associated with smoking. As Ghadirian (2005) explains, quitting smoking can greatly reduce the risks of cardiovascular disease: within a year of quitting, a former smoker's risk of heart disease is reduced by nearly 50%, compared to someone who continues to smoke (Ghadirian, 2005). A study conducted in men younger than age 55 revealed that while those who had quit smoking within the past year had a risk not significantly different from current smokers, the risk declined after 2 years to nearly that of non-smokers (Ghadirian, 2005). The residual risk for

cardiovascular disease following cessation is strongly dependent on total previous exposure to cigarette smoke, length of time without cigarettes, and the health status of the individual at the time of stopping. However, after 10 to 15 years without cigarettes, the health status of most former smokers is not significantly different from that of a lifelong non-smoker (Stephens & Canada. Health, 1999). This means that targeted smoking cessation strategies have the potential to improve disease risk rates and encourage better health in the future (Tjepkema, 2002).

7.2 Alcohol Abuse

According to National Cancer Institute, heavy alcohol use is defined as consumption of five or more drinks on a single occasion. The prevalence of heavy drinking on a weekly basis has been found to be higher in First Nations communities (16%) than in the general Canadian population (6.2%). The off-reserve Aboriginal population is less likely than the general population of Canada to be frequent drinkers (i.e. weekly), but is more likely to report higher levels of heavy drinking (National Cancer Institute, 2002). Consequently, the risks of heavy drinking on health are a serious concern for Canada's Aboriginal population.

Heavy drinking has been reported to increase the risks of developing cancers. In particular, high levels of consumption have been found to markedly increase the risk of liver and colorectal cancers. Consumption of just one drink per day for women, or two drinks per day for men, has been associated with an increased risk of developing cancers of the mouth, larynx, pharynx, oesophagus, and liver. Furthermore, women who have two drinks per day are at 25% higher risk of developing breast cancer than women who don't drink alcohol (National Cancer Institute, 2002). Finally, the combination of alcohol consumption and smoking greatly increases the risk of lung cancer.

As discussed earlier, alcohol abuse can be a chronic condition in and of itself. Its association, often, with depression, historical experiences, trauma, and other unpleasant memories or current situations, demonstrates that alcoholism has a profound effect on one's health and ability to function in the world around them. Thus, not only can alcohol influence and place people at risk for chronic conditions, but also its potential status as a chronic condition can create ongoing difficulties and additional problems for the user. Physical and psychosocial risks associated with alcoholism, therefore, need to be taken very seriously both in Aboriginal and non-Aboriginal communities.

7.3 Obesity and Inactivity

Obesity is an important risk factor for many chronic diseases. Obesity is often measured through body weight measures and/or the body mass index (BMI), which produces a measure based on one's height and weight. The percent of individuals with normal, higher or lower body mass index in Aboriginal and Canadian populations, reported in the 2002/03 Regional Health Survey (RHS) Report, is summarized in the table below.

	First Nations Adults	Canadian Adults
Normal	25.9%	49%
Overweight	37.0%	33%
Obese	31.2%	15%

Source: (First Nations Centre, 2005)

As also described in the 2002/03 RHS report, the distribution of obesity within the Aboriginal population is influenced by gender (First Nations Centre, 2005). For instance, men were found to be overrepresented in the group of overweight individuals, while Aboriginal women were more likely to be obese or morbidly obese individuals (MacMillan et al., 1996). It is important to note here that there have been concerns with the measurement of obesity for some Aboriginal groups, such as the Inuit. As has been shown among young arctic children, different patterns of growth and different height-to-weight gradients, which remain throughout adulthood, can cause an individual to be measured as obese when they are not (First Nations and Inuit Regional Health Survey National Steering Committee, 1999). The 1999 First Nations and Inuit Regional Health Survey (First Nations and Inuit Regional Health Survey National Steering Committee, 1999) found that 36% of Labrador Inuit women and 26% of Labrador Inuit men are overweight (McIntyre & Shah, 1986). The prevalence of obesity in Aboriginal population of Northern Ontario ranges from 50% to 70% in Aboriginal women and 30% to 50% among Aboriginal men (Young & Sevenhuysen, 1989). A study within an Ojibwa-Cree population found that in some age and sex groups, almost 90% of those studied were overweight and obese (Tjepkema, 2002). Further, there appears to be very little difference between the physical activity levels of the off-reserve Aboriginal population and the non-Aboriginal population in Canada located in the provinces. In the territories, however, Aboriginal people were less likely to be active than other northerners (Denny, 2005).

A key contributing factor to obesity in Aboriginal and non-Aboriginal populations is inactivity. Unfortunately rates of inactivity have been shown to be high in many Aboriginal communities. A study conducted in the U.S.A. in 2001 and 2002, which surveyed American Inuit and American Native (AI/AN) people's chronic disease risk factors, found that 37.2% of AI/AN reported no physical activity during their leisure time. The survey also found that 29.3% of the people surveyed were obese (OR=1.41)(First Nations Centre, 2005). Such inactivity has also been reported among the First Nations population. Because of the loss of First Nations traditional lands and practices, such as hunting, trapping and fishing, a higher proportion of Aboriginal people have begun to lead more sedentary lifestyle. In addition, there was an adoption of a non-traditional (or so-called "western"¹¹) diet by First Nations people after colonization. As a result of these and other socio-economic changes, the percentage of inactive and obese individuals in First Nations communities has increased (Canada, 2001). Despite the fact that the proportion of inactive and obese individuals is growing, they can be prevented by education about the importance of exercise and the promotion of active living. Thus, focussing on positive intervention strategies and treatments has the potential to improve future health.

¹¹ A Westernized diet is typically high in fat and protein and low in fiber.

7.4 Employment and Education

Because the average age of the Aboriginal population is 10 years younger than the general population, there will be large increases in the Aboriginal working-age population (25-44 years) over the next decade (Malatest, 2004). And, while the level of education for this age group has improved by 14 per cent over the decade – a greater increase than the 10% seen among the non-Aboriginal population – the gap between the two groups remains great (Malatest, 2004). For example, the proportion of Aboriginal people in their twenties with a post-secondary degree or diploma rose from 19% to 23% between 1981 and 1996, but the proportion of those with a university degree or certificate did not increase significantly (3% to 4%). Further still, education levels for Aboriginal Canadians remain below the national average: in 1996, 54% of the Aboriginal population aged 15 and over did not have a high-school diploma, compared to 35% of the non-Aboriginal population (Anderson, 2003). Education levels and employment rates are closely associated with one another (Tjepkema, 2002):

In 2000/01, the off-reserve Aboriginal population, as a whole and in various geographic regions, had lower levels of education attainment and household income and was less likely to have worked the entire year than the non-Aboriginal population (Statistics Canada, 2001).

According to the 2001 Census, the unemployment rate for Aboriginal adults aged 25 to 34 with university degrees was 8%, while that for those who had completed grade 9 but not high school was 28%. For those who had not completed grade 9 the unemployment rate was 40% (Statistics Canada, 2001). Researchers have also found that post-secondary educational attainment has some major positive influences on employment and earnings for Aboriginal peoples (Hull et al., 2000; Maxim, White, Whitehead, & Beavon, 2000).

Statistics on Aboriginal unemployment highlight the magnitude of this significant problem: in 1998, the average unemployment rate on Aboriginal reserves was 29%, which is also almost triple the national rate (Canada, 2001); (Canada. Parliament. House of Commons. Standing Committee on Health, 1995). The situation was even worse in some communities, where unemployment rates were reported to be as high as 90% (MacMillan et al., 1996). While some of the highest rates of unemployment can be found on reserves, an average of 25% of Aboriginal adults (ages 15+) in 1996 were thought to be unemployed, as compared with just under 10% of the mainstream population (Canada, 2001). The disparity in employment and its links to poverty is exemplified by the fact that in 1995, the average employment income of Aboriginal people was \$17,382, which is about 1.5 times lower than the national average of \$26,474 (MacMillan et al., 1996). In 1990, more than half (54%) of adult Aboriginal people reported annual incomes below \$10,000, while only 35 % of Canadians reported the same level of income (First Nations Centre, 2005; Oberle & INAC, 1993). More recent data has shown some improvements in employment rates of First Nations living in Canada: the 2002/03 RHS showed that 33.2% of First Nations adults who reported their income below \$10,000 and the overall employment rate of First Nations people was registered at 8 % lower than that of Canadian population in 2001 (First Nations Centre, 2005; Mendelson, 2004). More recent data have shown 5 to 7% improvement in employment rates from 1991 to 2000, and an equalization of employment rates

among Aboriginal people living on and off-reserve (Green et al., 2003).

While these statistics paint a picture of vulnerability in the socioeconomic landscape of Aboriginal Peoples in Canada, it is important to highlight here that while education and employment directly impact one's socioeconomic status, they also have a particular impact on one's health and well-being. In fact, it has been found that education and employment can be key predictors of chronic disease development and survival. For example, lower cancer survival rates have been linked to low income levels and high unemployment rates (Ward et al., 2004). A 2003 study found substantial clustering of diabetes in areas of Winnipeg with low socioeconomic status, poor environmental quality, poor lifestyles and a high concentration Aboriginal Peoples (Green *et al.*, 2003). The study also found that education and income were stronger predictors of diabetes than Aboriginal status, suggesting that socioeconomic status, rather than genetic factors were responsible for the high prevalence of diabetes (Health Canada, 2005).

7.5 Elder Health

In Canada, life expectancy at birth for the "registered Indian" population remains lower than that of the general Canadian population: 68.9 years for males and 76.6 years for females in 2000, difference of 7.4 years between Aboriginal and non-Aboriginal males and 5.2 years between Aboriginal and non-Aboriginal females (Durie, 2004). Not only is there a smaller population of elderly people, but Elders are generally younger in Aboriginal communities than non-Aboriginal communities. Of course, a distinction must be made between those who are elderly by nature and those who are considered "Elders" in their communities because of the strength and wisdom that they hold. While age often runs parallel to the classification of being an Elder, the experience, knowledge, and wisdom that the person has is far superior. In this section the health of the elderly and elders in Aboriginal populations will be discussed in terms of being defined as the older subset of the population.

Not surprisingly, the risks attributed to elders' health are largely a result of increased age. Yet, because of a generally lower life expectancy and younger population, the particularities of the health of the older Aboriginal population and the risks associated with later life and chronic diseases has not been robustly explored in the literature. What has been noted in the Canadian literature is that 1 in 3 older Native Americans lived below the poverty level (Cueller, 1990). This means that many elderly Aboriginal people continue to struggle with their socioeconomic status and, therefore, likely do not have the monetary power to help manage and control the inevitable increase in health conditions that come with age. This raises concern not only for the health and well-being of the elderly in Canadian Aboriginal populations, but also their basic subsistence and ability to survive without further monetary support. It also raises concerns for the community: because elders traditionally play such an important role in Aboriginal communities, the loss of their strength and ability to engage in cultural activities because of monetary or health conditions is concerning.

In a 1997 New Zealand study (Durie, Allan, & Cunningham, 1997), the connection between cultural and community engagement and health was assessed. The assessment of health and well-being among the elder population was based on Maori health perspectives and also took into account the importance of elders in Maori society (a role and function that is similar to that of the

elders in Canadian Aboriginal populations). In total, 400 Maori participants over the age of 60 years participated. The research found that: "in addition to economic and social considerations, well-being for older Maori was therefore conceptualized as an interaction between personal health perspectives and participation in certain key elements of Maori society e.g. land, language, marae (tribal gathering places)" (Durie et al., 1997). Taking this information further, the study reported that Maori elders that ranked lowest on the "cultural index scale" (i.e. those less involved or less able to fulfill their cultural role) were also the most likely to have poor health; this was the case even for individuals that had similar basic standards of health and environmental circumstances. As such, the researchers concluded that: "a Maori view of well-being is closely linked to an ability to fulfill a cultural role. Measures of well-being that do not capture cultural identity will not be able to convey the nature of wellbeing, as it applies to Maori" (Dion Stout & Kipling, 2003; Durie et al., 1997). This connects to and builds on the understanding of health developed throughout this book; that health is more than one's ability to avoid disease and reach specific measures, but that it also depends on broader socio-economic factors that influence one's emotional, spiritual, mental, and economical well-being.

As this section shows, the risks associated with chronic disease development increase with age, due to the accumulation of risks across the life stages. Therefore, adulthood becomes an arena where chronic disease management becomes paramount and issues related to support systems and cultural practices become evermore important; this is especially true in vulnerable populations, such as the Aboriginal population in Canada. In preparing for this, it is important that the public health system design support services and education programs for the elderly so that diseases can be managed and accumulated risks can be held off. The health experiences of the eldest population viewed through a life course perspective helps us to understand the necessity of focusing on prevention and health promotion at the earliest stages of life and continuing this vigilance throughout life.

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**Les déterminants sociaux de la santé chez les
Autochtones :
Approche fondée sur le parcours de vie**

Rapport présenté par

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au

Sous-comité sénatorial sur la santé de la population

30 mars 2009

TABLE DES MATIERES

SYNTHÈSE	A-1
ÉLIMINONS MAINTENANT LA PAUVRETÉ	A-1
MESURES À PRENDRE	A-3
FARDEAU DES MALADIES CHRONIQUES AU SEIN DES POPULATIONS AUTOCHTONES DU CANADA	A-4
1. INTRODUCTION.....	A-4
2. FARDEAU DU DIABÈTE AU SEIN DES POPULATIONS AUTOCHTONES A-4	
2.1 DÉFINITION DU DIABÈTE ET DE L'INTOLÉRANCE AU GLUCOSE.....	A-4
2.2 FARDEAU DU DIABÈTE DE TYPE 2 AU SEIN DES POPULATIONS AUTOCHTONES	A-4
2.3 COMPRENDRE LES STATISTIQUES POUR MAINTENANT ET POUR L'AVENIR.....	A-8
3. FARDEAU DES MALADIES CARDIOVASCULAIRES AU SEIN DES POPULATIONS AUTOCHTONES	A-8
3.1 DÉFINITION ET DESCRIPTION DES MALADIES CARDIOVASCULAIRES.....	A-8
3.2 FARDEAU DES MALADIES CARDIOVASCULAIRES AU SEIN DES POPULATIONS AUTOCHTONES	A-9
4. FARDEAU DES MALADIES RESPIRATOIRES CHRONIQUES AU SEIN DES POPULATIONS AUTOCHTONES	A-11
4.1 DÉFINITION ET DESCRIPTION DES MALADIES RESPIRATOIRES CHRONIQUES	A-11
4.2 FARDEAU GÉNÉRAL DES MALADIES RESPIRATOIRES CHRONIQUES AU SEIN DES POPULATIONS AUTOCHTONES	A-11
4.3 TUBERCULOSE	A-11
4.4 OTITE MOYENNE CHRONIQUE.....	A-13
4.5 INFECTIONS RESPIRATOIRES CHRONIQUES OU RÉCURRENTES ...	A-15
4.6 BRONCHO-PNEUMOPATHIE CHRONIQUE OBSTRUCTIVE (BPCO) ET ASTHME	A-17
5. FARDEAU DES AFFECTIONS MUSCULO-SQUELETTIQUES AU SEIN DES POPULATIONS AUTOCHTONES	A-19
5.1 DÉFINITION ET DESCRIPTION DES MALADIES ET TROUBLES MUSCULO-SQUELETTIQUES.....	A-19
5.2 FARDEAU DE L'ARTHRITE AU SEIN DES POPULATIONS AUTOCHTONES	A-20

5.3 OSTÉOPOROSE	A-22
6. FARDEAU DU CANCER AU SEIN DES POPULATIONS AUTOCHTONES	A-23
6.1 DÉFINITION ET DESCRIPTION DU CANCER	A-23
6.2 SURVEILLANCE DU CANCER AU SEIN DES POPULATIONS AUTOCHTONES	A-23
6.3 FARDEAU DU CANCER AU SEIN DES POPULATIONS AUTOCHTONES	A-25
PROVINCE	A-26
LITTÉRATURE CONNEXE	A-26
7. FARDEAU DES MALADIES MENTALES GRAVES DANS LES POPULATIONS AUTOCHTONES	A-30
7.1 DÉFINITION ET DESCRIPTION DE « MALADIE MENTALE CHRONIQUE »	A-30
7.2 FARDEAU DES MALADIES MENTALES GRAVES AU SEIN DES POPULATIONS AUTOCHTONES	A-30
7.3 FARDEAU DES MALADIES MENTALES GRAVES POUR LA SANTÉ DES COMMUNAUTÉS.....	A-38
8. RÉPERCUSSIONS DES MALADIES CHRONIQUES SUR LA SANTÉ MENTALE	A-38
8.1 DÉFINITION DES PARAMÈTRES DE L'ASSOCIATION ENTRE MALADIE CHRONIQUE ET SANTÉ MENTALE.....	A-39
8.2 ANALYSE DE L'ASSOCIATION ENTRE MALADIE CHRONIQUE ET SANTÉ MENTALE	A-41
8.3 THÈMES COMMUNS.....	A-51
8.4 COMORBIDITÉ.....	A-57
UNE APPROCHE FONDÉE SUR LE PARCOURS DE VIE : LES FACTEURS DE RISQUE DE MALADIES CHRONIQUES DANS LES POPULATIONS AUTOCHTONES AU CANADA	A-60
1. INTRODUCTION : ADOPTION D'UNE APPROCHE FONDÉE SUR LE PARCOURS DE VIE.....	A-60
1.1 PERSPECTIVE DU PARCOURS DE VIE ET SANTÉ DES AUTOCHTONES	A-61
1.2 APPLICATION DE L'APPROCHE FONDÉE SUR LE PARCOURS DE VIE	A-62
2. FACTEURS DE RISQUE COMMUNAUTAIRES	A-63
2.1 FACTEURS DE RISQUE SOCIO-ÉCONOMIQUES.....	A-63

PROBLÈMES DE SANTÉ MENTALE	A-71
2.2 FACTEURS DE RISQUE GÉOGRAPHIQUES	A-75
3. FACTEURS DE RISQUE PRÉNATAUX	A-82
3.1 DIABÈTE MATERNEL	A-82
3.2 OBÉSITÉ MATERNELLE.....	A-83
3.3 USAGE DU TABAC CHEZ LA MÈRE	A-83
3.4 CONSOMMATION D'ALCOOL PAR LA MÈRE	A-85
4. FACTEURS DE RISQUE À LA NAISSANCE	A-87
4.1 POIDS ANORMAL À LA NAISSANCE.....	A-87
4.2 ALLAITEMENT MATERNEL	A-89
5. FACTEURS DE RISQUE CHEZ LA PETITE ENFANCE	A-91
5.1 INFLUENCES SUR LA POPULATION	A-92
5.2 PAUVRETÉ ET FAIM CHEZ LES ENFANTS.....	A-92
5.4 TABAGISME CHEZ LES PARENTS ET FUMÉE À LA MAISON.....	A-97
6. FACTEURS DE RISQUE À L'ENFANCE ET À L'ADOLESCENCE	A-98
6.1 L'OBÉSITÉ INFANTILE.....	A-98
6.2 TABAGISME	A-100
6.3 SANTÉ SEXUELLE	A-103
6.4 ÉDUCATION	A-105
6.5 PLACEMENT EN FAMILLE D'ACCUEIL, TUTELLE ET SERVICES À L'ENFANCE AUTOCHTONE.....	A-110
7. FACTEURS DE RISQUE CHEZ LES ADULTES ET LES ÂÎNÉS.....	A-113
7.1 USAGE DU TABAC	A-113
7.2 ABUS D'ALCOOL	A-114
7.4 EMPLOI ET SCOLARITÉ	A-116
7.5 SANTÉ DES ÂÎNÉS	A-118

Synthèse

Il a été établi il y a près de deux décennies que les facteurs qui déterminent la santé et le bien-être des communautés autochtones du Canada ont leurs origines dans les forces historiques, culturelles, sociales, économiques et politiques qui agissent en amont sur la vie des Autochtones.

De nombreux déterminants de la santé des Autochtones n'entrent pas dans le cadre du système de soins de santé. Ce sont par exemple l'adoption d'un régime alimentaire qui s'écarte des traditions, l'insécurité alimentaire, le stress dû à des facteurs économiques, la pollution, la détérioration de l'environnement et le capitalisme mondial.

Il importe de comprendre que les termes utilisés et leur interprétation sont essentiels dans le discours sur les déterminants de la santé, tout particulièrement si l'objectif est de mieux saisir les causes. Les Autochtones n'ont jamais été des participants à part entière dans l'État-nation qu'est le Canada. L'évolution de l'économie politique canadienne les a forcés à quitter leurs terres ancestrales pour faire place aux sociétés colonisatrices. Ces déplacements attribuables à la colonisation ont eu pour conséquence d'exclure socialement beaucoup de communautés autochtones du reste du Canada. L'exclusion sociale a conduit à leur marginalisation dans les secteurs de l'éducation, de l'emploi, du logement, des soins de santé et bien d'autres et, par conséquent, à l'instauration d'une société à deux niveaux : les Canadiens d'un côté et les Autochtones de l'autre.

Aussi difficile à accepter que cela puisse paraître, les faits exposés dans le présent document démontrent abondamment les inégalités que vivent les Autochtones au Canada. Les Autochtones s'exposent à des risques pour la santé qui sont supérieurs dans presque toutes les catégories évaluées, d'où les profondes disparités existantes, surtout chez les plus vulnérables, à savoir les enfants et les aînés.

Les déterminants sociaux sont souvent appelés les « causes des causes ». Autrement dit, la maladie, l'incapacité et le décès sont influencés par des facteurs de risque individuels tels que l'usage du tabac, l'obésité et l'abus d'intoxicants. On a critiqué ces facteurs de risque en disant qu'ils jetaient le blâme sur la victime, car il est maintenant établi qu'ils sont socialement ancrés dans la vie collective des particuliers, des familles, des communautés, des régions et des États-nations. Par conséquent, les disparités dans les déterminants sociaux appellent des solutions d'ordre social.

Éliminons maintenant la pauvreté

L'élimination de la pauvreté est le principal déterminant de la santé. C'est en effet par le revenu que passent les autres déterminants de la santé : logement convenable, accès à des services de santé et d'éducation, eau potable, aliments nutritifs, etc.

Selon un récent rapport produit par les docteurs Charlotte Loppie Reading et Fred Wein (2009) et commandé par le Centre de collaboration nationale de la santé autochtone de l'Agence de la santé publique du Canada, les Autochtones sont aux prises avec des disparités en matière de santé que les modèles généraux ne peuvent permettre d'expliquer ou de comprendre. Par exemple, une étude a servi à comparer des Autochtones hors réserve et des non-Autochtones, les

deux groupes vivant en milieu urbain et ayant un niveau semblable de faible revenu; il est ressorti que le groupe autochtone avait connu beaucoup plus d'épisodes dépressifs majeurs – 21 % – que le groupe non autochtone – 13 % (Loppie Reading et Wien, 2009). Il y a d'autres éléments que le revenu et la géographie qui entrent en jeu. Fait intéressant, l'écart entre les deux groupes pour les épisodes dépressifs se rétrécissait à mesure que le revenu augmentait, si bien qu'au niveau de revenu supérieur la différence devenait statistiquement non significative (Loppie Reading et Wien, 2009).

Pour bien étudier les origines de la santé chez les Autochtones, il faut se pencher sur les particularités des facteurs sociopolitiques en adoptant une conception holistique de la santé qui prévoit l'optimisation de la santé à chaque étape du parcours de vie, de la période avant la conception à la mort.

Les déterminants ont été subdivisés en trois groupes. Il y a d'abord les déterminants « proximaux », notamment les comportements liés à la santé, l'environnement physique, l'emploi, le revenu, l'éducation et l'insécurité alimentaire. Les déterminants « intermédiaires » se trouvent en amont des déterminants proximaux et incluent les systèmes de santé et d'éducation, les infrastructures, les ressources et les capacités communautaires, la gérance de l'environnement et la continuité culturelle. Enfin, Loppie Reading et Wein (2009) font état des déterminants distaux, notamment le colonialisme, le racisme et l'exclusion sociale, et de la nécessité de *l'autodétermination dans la progression vers le rétablissement des populations*.

L'objectif est d'optimiser le développement pendant tout le parcours de vie. Il s'agit de s'attaquer à l'interaction complexe des déterminants de la santé à la lumière du contexte et de l'histoire qui sont à la source de la situation actuelle, en particulier du contexte autochtone, pendant le parcours de vie.

Il est proposé d'établir un modèle de santé des populations de type communautaire qui aborderait les déterminants de la santé et faciliterait l'instauration d'une approche pangouvernementale de la santé des populations autochtones au niveau fédéral. Le modèle devrait *prévoir la création d'une alliance stratégique permettant de relier les déterminants de la santé*.

D'après le troisième rapport du Comité, une bonne trentaine de ministères et d'organismes fédéraux offrent plus de 360 programmes et services aux Autochtones, dont plus de la moitié (190) s'adressent à tous les groupes et le reste, à des groupes en particulier (Sous-comité sénatorial sur la santé des populations, 2008). Les six thèmes centraux de l'alliance stratégique proposée sont l'éducation, la prévention et l'intervention communautaires, la santé mentale, le logement, le développement économique et l'investissement dans les capacités pour constituer un effectif complet de professionnels de la santé des Autochtones à tous les niveaux.

Comme environ la moitié des Autochtones ont moins de 25 ans, il est logique de vouloir investir amplement dans la santé de la génération future, sans pour autant faire fi des besoins actuels. Aux premières étapes (santé de la mère avant la conception, périodes prénatale et postnatale), la vie est presque totalement dépendante de la mère. Bien que la malléabilité de l'enfant soit à son maximum dans les premières années, les fonds sont surtout investis dans la santé, l'éducation et le bien-être général aux stades ultérieurs : on dépense le moins pour la petite enfance et le plus pour la fin de la vie.

Selon l'Enquête régionale sur la santé, la condition socio-économique et le niveau de scolarité des parents influent directement sur le soutien social et le bien-être des enfants (Centre des Premières nations, 2005). L'éducation des enfants fait donc partie des solutions tout indiquées. Les études de suivi longitudinales des programmes d'aide préscolaire ont montré que ces programmes contribuent à augmenter le niveau de scolarité et à diminuer les taux d'aide sociale, de criminalité et de grossesse à l'adolescence.

Mesures à prendre

Adopter une approche pangouvernementale.

Soutenir les Autochtones dans leur quête légitime d'autodétermination. Dans le domaine de la santé, cela signifie l'établissement de **régies régionales de la santé** dirigées par des Autochtones et financées par le gouvernement fédéral et la province.

Demander aux organisations politiques autochtones, aux provinces, aux territoires et au gouvernement fédéral de s'engager à tenir des discussions pluriannuelles pour étudier les questions d'intérêt commun et les mesures à mettre en œuvre en vue de l'amélioration de la santé et du bien-être des Autochtones.

Faciliter et accélérer la diffusion et le transfert des connaissances ainsi que leur application à des utilisations et avantages potentiels, soit des politiques, des interventions, des services et des produits.

Encourager les initiatives de collaboration multilatérales auprès des collectivités et des institutions qui ont à cœur d'améliorer la santé et le bien-être des Autochtones. Promouvoir la collaboration multidisciplinaire, multi-institutionnelle et multisectorielle et tirer parti des réseaux existants de décideurs et de chercheurs pour renforcer les capacités dans les domaines prioritaires d'intérêt commun touchant à la santé des Autochtones.

Je laisse le dernier mot au Sous-comité sénatorial sur la santé des populations, qui a écrit dans son quatrième rapport :

Le Sous-comité croit qu'il est inacceptable qu'un pays privilégié comme le Canada continue à tolérer de telles disparités en matière de santé.

(Sous-comité sénatorial sur la santé des populations, 2008).

FARDEAU DES MALADIES CHRONIQUES AU SEIN DES POPULATIONS AUTOCHTONES DU CANADA

1. Introduction

D'après les indicateurs internationaux de la santé, les Canadiens jouissent d'une des meilleures santés au monde. Pourtant, le bien-être des Autochtones du Canada se compare à celui des populations de nombreux pays en développement (Cooke, Beavon et McHardy, 2004). En témoigne l'effet croissant des maladies chroniques sur les taux de morbidité et de mortalité des Autochtones : bien que les maladies transmissibles aient diminué en importance, les maladies chroniques ont progressé jusqu'à devenir un important problème de santé (Smeja et Brassard, 2000). Des études antérieures et actuelles ont prouvé que les Autochtones du Canada sont aux prises avec un fardeau beaucoup plus lourd que les non-Autochtones pour certaines maladies chroniques : près du tiers des Autochtones de plus de 15 ans ont dit avoir reçu un diagnostic de maladie chronique d'un professionnel de la santé (MacMillan, MacMillan, Offord et Dingle, 1996). Par exemple, en 2000-2001, 60,1 % des Autochtones hors réserve, contre 49,6 % des non-Autochtones, ont déclaré avoir au moins une maladie chronique (Tjepkema, 2002). Les statistiques qui montrent une forte prévalence de nombreuses maladies chroniques de base sont particulièrement préoccupantes. Le fardeau et les tendances des six maladies ou groupes de maladies chroniques de base suivantes chez les Autochtones seront étudiés à fond : 1) diabète, 2) maladies cardiovasculaires, 3) maladies respiratoires chroniques, 4) troubles musculo-squelettiques, 5) cancer et 6) maladies mentales graves. De plus, nous examinerons l'effet des maladies chroniques sur la santé mentale ainsi que la comorbidité entre les différentes maladies.

2. Fardeau du diabète au sein des populations autochtones

2.1 Définition du diabète et de l'intolérance au glucose

Le diabète fait partie des maladies chroniques des Autochtones les plus déclarées et les plus étudiées en raison de son récent statut de maladie « épidémique » au sein de ces populations. Dans ce contexte, le diabète s'entend surtout du diabète non insulino-dépendant, ou diabète de type 2.

2.2 Fardeau du diabète de type 2 au sein des populations autochtones

Le diabète chez les Autochtones est considéré comme une « nouvelle » maladie, qui a rapidement pris de l'ampleur et de l'importance. Il n'est dépisté que depuis 50 ans dans les populations autochtones du Canada (Santé Canada, 2000; Young, Reading, Elias et O'Neil, 2000). La progression suivie de l'incidence et de la prévalence du diabète a amené les chercheurs, les décideurs et les communautés autochtones elles-mêmes à désigner cette maladie comme « épidémique » (Young et coll., 2000). On s'inquiète non seulement de sa prévalence, de sa prise en charge et de la nécessité de bons programmes de prévention, mais aussi de ses complications graves et de ses liens avec d'autres maladies chroniques (Young et coll., 2000). Les complications touchent l'appareil circulatoire, les yeux, les reins, le parodonte et le système nerveux et peuvent donner lieu à une mortalité prématurée, à des incapacités et à une qualité de vie amoindrie. Une étude réalisée au Manitoba a établi des projections sur l'ampleur du problème au sein des populations autochtones : on évalue qu'entre 1996 et 2016, uniquement à cause du diabète, il y aura dix fois plus de maladies cardiovasculaires, cinq fois plus d'accidents

vasculaires cérébraux, dix fois plus de mises en dialyse, dix fois plus d'amputations des extrémités inférieures et cinq fois plus de cécité (Greene, Blanchard et Wajda, 1999).

2.2.1 Prévalence du diabète chez les Premières nations, les Métis et les Inuits

Comme la prévalence du diabète varie selon les origines, le groupe linguistique, l'aire culturelle et la situation géographique (Delisle, Rivard et Ekoe, 1995), de nombreuses études menées sur cette maladie au sein des populations autochtones ont visé expressément une communauté, une nation, un conseil tribal, une population ou une province en particulier. Il s'ensuit que l'Enquête auprès des peuples autochtones de 1991 est la seule source de données nationales sur la prévalence du diabète chez les Premières nations, les Métis et les Inuits (Waldram, Herring et Young, 2006). Selon les données sur le diabète autodéclaré qui ressortent de cette enquête, la prévalence est plus faible dans les populations inuites qu'au sein des Premières nations et des populations métisses (Bruce, Kliever, Young, Mayer et Wajda, 2003).

À mesure que le Nord accroît ses contacts avec le Sud et les grands centres urbains, les communautés inuites deviennent plus susceptibles, croit-on, de contracter des maladies « occidentales » comme le diabète (Bobet, 1997; Bruce, 2000, 2000; Greene et coll., 1999; Hegele et coll., 1999; McIntyre et Shah, 1986; Montour, Macaulay et Adelson, 1989; Young et coll., 2000). La réalité de ce risque se manifeste par l'augmentation rapide du diabète chez les Inuits du Canada (Anderson, 2004; Young, Moffatt et O'Neil, 1993) : la prévalence chez les Inuits du Labrador est passée de 1,9 % de la population en 1991 à 4 % en 1999 (Comité directeur national de l'Enquête sur la santé des Premières nations et des Inuits, 1999). Cette évolution récente confirme que l'isolement géographique, les contacts tardifs avec les colons européens et la préservation du mode de vie traditionnel ont eu pour effet de protéger les communautés autochtones du Nord.

Le diabète est un problème grandissant dans la population inuite, mais, chez les Premières nations du Canada, il a régulièrement été signalé comme un problème de santé chronique. Toutefois, son ampleur et son importance véritables n'ont pas encore été déterminées. Par exemple, l'Enquête auprès des populations autochtones a permis de constater que la prévalence brute du diabète était de 6,4 % et de 8,5 %, respectivement, pour les membres des Premières nations vivant dans une réserve et hors réserve (Bobet, 1998). En revanche, l'Enquête régionale sur la santé de 2002-2003 a fait ressortir une prévalence normalisée selon l'âge de 19,7 % chez les Premières nations. Pour les personnes de 55 ans ou plus, le taux était de 35 % (Centre des Premières nations, 2005). Un membre sur quatre des Premières nations vivant dans une réserve et âgé de plus de 45 ans avait le diabète (Centre des Premières nations, 2004). Ces résultats ultérieurs de l'Enquête régionale indiquent que la prévalence du diabète au sein des communautés des Premières nations pourrait avoir augmenté depuis 1991. Des données du Manitoba puisées dans les bases de données provinciales sur l'hospitalisation et les visites chez le médecin appuient cette hypothèse : on observe une hausse de la prévalence du diabète depuis les années 1990 au sein des Premières nations (Green, Blanchard, Young et Griffith, 2003).

Bien que des études aient montré que le diabète est une préoccupation pour toutes les Premières nations du Canada, il importe de prendre en considération les variantes régionales et communautaires. Les données propres à des régions ou à des communautés sont plus spécifiques et mettent en relief les différentes facettes du problème. À titre d'exemple, une étude réalisée chez les Oji-Cris a révélé une prévalence extrêmement élevée (40 %) du diabète de type 2 et de

l'intolérance au glucose; ce taux est le plus haut du monde pour une sous-population et il équivaut à cinq fois la moyenne canadienne (Harris et coll., 1997).

On en sait beaucoup moins sur le diabète dans la population métisse, mais le taux est comparable ou inférieur à celui des Premières nations pour la plupart des groupes d'âge et de sexe (Bruce, Kliever, Young, Mayer et Wajda, 2003; Santé Canada, 2000). Les données nationales, toutefois, donnent à penser que le taux de diabète est généralement plus haut chez les Premières nations et les Métis que chez les Inuits et les Canadiens en général. Une hausse plus faible et un taux de prévalence plus bas ont été relevés dans la population métisse, mais les chiffres restent tout de même supérieurs à la moyenne nationale : la prévalence brute du diabète chez les Métis était de 5,5 % en 1991, comparativement à 3,1 % dans la population en général. D'après le Ralliement national des Métis, le taux de diabète de cette population était de 5,9 % en 2006 (Ralliement national des Métis, 2006).

2.2.2 Stratification selon le sexe

En 1997, le taux de diabète autodéclaré chez les hommes et les femmes des Premières nations était respectivement 3,6 et 5,3 fois plus élevé que chez les non-Autochtones des mêmes sexes et groupes d'âge (Centre des Premières nations, 2004). Ces différences montrent une fois de plus le fossé qui sépare les Autochtones et les non-Autochtones pour ce qui est du diabète, mais elles font aussi ressortir la stratification de cette maladie selon le sexe. Parce que l'écart entre les sexes jette une lumière importante sur le fardeau du diabète au sein des populations autochtones du Canada, nous passerons en revue la littérature pertinente sur la question.

Dans une étude menée auprès de deux communautés algonquines du Nord-Est du Québec (Delisle et coll., 1995) et de la communauté oji-crie de Sandy Lake dans le Nord-Ouest de l'Ontario (Harris, Caulfield, Sugamori, Whalen et Henning, 1997), il est ressorti que la prévalence du diabète de type 2 atteignait 80 % chez les femmes de 50 à 64 ans. Selon les données nationales, les femmes comptent pour les deux tiers environ des cas de diabète diagnostiqués au sein des Premières nations (Bobet, 1997); dans la population canadienne en général, c'est l'inverse qui est vrai : la prévalence est généralement plus élevée chez les hommes que les femmes (Santé Canada, 1999). Outre qu'elles ont une prévalence plus élevée du diabète de type 2, les femmes autochtones sont nombreuses à recevoir un diagnostic de diabète gestationnel (Mohamed et Dooley, 1998).

Le diabète gestationnel se définit médicalement comme tout état d'intolérance au glucose apparu au début de la grossesse ou diagnostiqué pour la première fois durant la grossesse (Matthews, 2003). Il est établi que la tolérance au glucose s'amointrit chez toutes les femmes enceintes par suite des changements physiologiques et hormonaux qui accompagnent la grossesse (Hod, 2003). Dans le monde occidental, la tolérance au glucose descend suffisamment pour répondre aux critères de diagnostic du diabète gestationnel dans environ 2 ou 3 % des grossesses (Whitaker, Pepe, Seidel, Wright et Knopp, 1998). Des études menées dans le Nord du Québec et en Ontario révèlent que le diabète gestationnel peut toucher jusqu'à 13 % des grossesses chez les Autochtones (Godwin, Muirhead, Huynh, Helt et Grimmer, 1999; Harris et coll., 1997; Rodrigues, Robinson et Gray-Donald, 1999). Il a été dit que la difficulté de recueillir des données sur les taux de prévalence du diabète gestationnel pourrait expliquer partiellement les taux élevés constatés dans beaucoup de communautés autochtones : par exemple, le premier diagnostic du diabète de type 2 pendant la grossesse est intégré aux statistiques, et non le diabète

gestationnel comme agent étiologique. Cependant, certaines études ont permis de constater qu'un peu moins de la moitié des grossesses des femmes de 35 ans et plus sont associées au diabète de type 2 préexistant ou au diabète gestationnel (Harris et coll., 1997). Cette information soulève de sérieuses préoccupations au sujet du diabète chez les femmes autochtones.

Les taux de prévalence, les facteurs de risque et les résultats du diabète gestationnel chez les femmes autochtones et non autochtones ont été directement comparés pour la première fois dans une étude réalisée en Saskatchewan (Dyck, Klomp, Tan, Turnell et Boctor, 2002). Cette étude a révélé que, dans le district de santé de Saskatoon, les taux de prévalence sur un an pour le diabète gestationnel étaient de 3,7 % chez les femmes non autochtones et de 6,4 % chez les femmes autochtones. Pour les résidants de l'extérieur de ce district, ils étaient de 3,1 % et de 22,8 % respectivement (Dyck et coll., 2002). La plus grande crainte concernant le diabète gestationnel et l'existence ou le risque du diabète chez la mère est la persistance de la maladie après la grossesse. Par exemple, il est ressorti d'une étude effectuée dans la zone de Sioux Lookout que 70 % des femmes ayant reçu un diagnostic de diabète gestationnel avaient fini par être atteintes de diabète véritable dans un délai de trois ans (Mohamed et Dooley, 1998). Il est donc pressant de cibler le diabète chez les femmes des communautés autochtones.

2.2.3 Fardeau du diabète chez les enfants

La prévalence accrue du diabète chez les jeunes autochtones et la prévalence démesurément élevée des cas d'apparition prématurée du diabète au sein des populations autochtones soulèvent des préoccupations pour les enfants et les jeunes. Ainsi, une étude sur les taux de diabète chez les Haïda Gwaii de la Colombie-Britannique a permis de constater que 17 % des adultes de 35 ans et plus avaient le diabète de type 2 (Grams et coll., 1996). Des comparaisons entre des communautés des Premières nations et la population en général montrent que plus de la moitié (53 %) des membres des Premières nations vivant dans des communautés autochtones et atteints du diabète ont 40 ans ou moins et 65 % ont moins de 45 ans (Comité directeur national de l'Enquête sur la santé des Premières nations et des Inuits, 1999). Comme le montre à l'évidence l'appellation traditionnelle de « diabète de l'adulte », le diabète de type 2 n'était généralement pas observé chez les jeunes (Santé Canada, 2000). Les nouveaux cas dépistés chez les enfants des Premières nations, par exemple chez des enfants de 5 à 8 ans de la région d'Island Lake dans le Nord-Est du Manitoba (Dean, Mundy et Moffatt, 1992) et dans le Nord de l'Ontario (Harris, Perkins et Whalen-Brough, 1996), ont remis cette appellation en question. De plus, le dépistage du diabète par la mesure du glucose plasmatique à jeun dans une communauté ojibwa-crie éloignée du Nord a révélé un fort taux de prévalence (3,6 %) chez les filles et les femmes de 10 à 19 ans (Dean, 1998; Dean, Young, Flette et Wood-Steiman, 1998).

En général, les Autochtones sont plus jeunes que le reste de la population au moment du diagnostic et à l'apparition des complications, et la maladie est plus grave au moment du diagnostic (Goulet et coll., 2006; Santé Canada, 2000; Ho, Gittelsohn, Harris et Ford, 2006; Meatherall et coll., 2005; Pohar et Johnson, 2007; Simpson, Corabian, Jacobs et Johnson, 2003). Malgré leur jeune âge, les Autochtones ont aussi des taux de mortalité, de complication et d'hospitalisation plus élevés et des séjours plus longs à l'hôpital (Goulet et coll., 2006; Santé Canada, 2000; Pohar et Johnson, 2007; Simpson et coll., 2003). Cette situation cause de sérieuses préoccupations pour la santé et le bien-être des générations futures.

2.3 Comprendre les statistiques pour maintenant et pour l'avenir

Les statistiques existantes sur le diabète des Autochtones du Canada nous disent que la répartition du diabète dans ce groupe varie sensiblement selon le sexe, la région géographique, la langue, l'aire culturelle, la latitude, la longitude et le degré d'isolement (Boston et coll., 1997; Santé Canada, 2000; Jin, Martin et Sarin, 2002; Macaulay et coll., 2003; Travers, 1995; Young, Reading, Elias et O'Neil, 2000; Young, Szathmary, Evers et Wheatley, 1990). En général, la prévalence est plus élevée dans le Sud que dans le Nord, chez les femmes que chez les hommes, chez les moins instruits et chez les Autochtones acculturés et vivant en milieu urbain (Bruce et coll., 2003; Daniel, Gamble, Henderson et Burgess, 1995; Santé Canada, 2005; Jin, Martin et Sarin, 2002; Travers, 1995; Young et coll., 1990; Zimmet, Dowse, Finch, Serjeantson et King, 1990). Malgré les enseignements que l'on peut tirer de ces chiffres, on peut se demander si le nombre de diagnostics de diabète déclaré est fiable pour déterminer les taux de prévalence : comme l'apparition du diabète se produit en moyenne quatre à sept ans avant le diagnostic, les cas diagnostiqués ne représentent pas le fardeau total de la maladie (Centre des Premières nations, 2005; McKinlay et Marceau, 2000; Young et coll., 2000). Par exemple, au Manitoba, le diabète non diagnostiqué constitue le tiers environ des cas de diabète (Bruce et coll., 2003) et, à l'échelle du Canada, le nombre réel de diabétiques est probablement le double ou le triple du nombre de cas diagnostiqués (Santé Canada, 2000).

Qui plus est, étant donné l'apparition plus rapide du diabète et les taux élevés dans la population autochtone, l'impact de cette maladie sur la santé des générations futures est inquiétant. On a par exemple émis l'hypothèse que, si cette tendance se poursuit, le nombre d'Autochtones qui ont le diabète au Canada triplera d'ici 2016 (Jin et coll., 2002).

3. Fardeau des maladies cardiovasculaires au sein des populations autochtones

3.1 Définition et description des maladies cardiovasculaires

Les maladies cardiovasculaires ont la réputation d'occasionner le plus gros fardeau économique de toutes les maladies traitées au Canada (Santé Canada, 2003, 2005; Lidgren, 2003). Depuis les années 1960, elles sont en recul en Amérique du Nord (Dorner et Rieder, 2004) : la réduction de l'incidence et de la mortalité est surtout due aux changements dans le style de vie et le comportement des gens, comme un meilleur régime alimentaire, de l'exercice physique plus fréquent et l'abandon du tabac (Sytkowski, D'Agostino, Belanger et Kannel, 1996). En dépit de ces changements, les maladies cardiovasculaires demeurent la principale cause de décès dans la plupart des pays occidentaux (Dorner et Rieder, 2004). À cause de leur fardeau économique, social et personnel, les maladies cardiovasculaires sont d'importantes maladies chroniques dont les effets sur la population autochtone du Canada doivent être débattus et examinés.

En vue de combattre la situation critique actuelle au Canada, on a créé un comité directeur chargé d'élaborer la Stratégie canadienne de santé cardiovasculaire et le plan d'action connexe, l'idée étant de fixer des cibles ambitieuses pour 2020 et de formuler des recommandations visant à les atteindre. Une de ces cibles consiste à mettre fin à la situation de crise touchant les maladies cardiovasculaires chez les Autochtones en réduisant leur fardeau au niveau de celui des autres Canadiens. Pour l'atteinte de cette cible, il est recommandé d'adopter une approche concertée qui fait intervenir les communautés autochtones et le gouvernement, d'établir un centre national

pour la prévention et la gestion des maladies chroniques des Autochtones et d'aider les Autochtones à mener une vie plus saine adaptée à leurs réalités culturelles (Comité, 2009).

Il faut faire attention lorsqu'on parle de maladies cardiovasculaires, car ce terme recouvre une catégorie hétérogène de maladies qui concernent le cœur ou l'appareil circulatoire (Waldram et coll., 2006). La maladie cardiovasculaire la plus courante est la coronaropathie, aussi connue sous le nom de cardiopathie ischémique ou de maladie des artères coronaires. La coronaropathie est l'affection causée par l'accumulation de dépôts gras dans les cellules qui tapissent les parois des artères coronaires, principale source d'alimentation en sang pour le cœur. À mesure que les dépôts s'épaississent, les artères se durcissent et rétrécissent (artériosclérose). Il en résulte une diminution de l'apport de sang oxygéné au muscle cardiaque, et cette ischémie peut causer des dommages permanents au cœur. Le blocage complet des artères coronaires entraîne une crise cardiaque (infarctus du myocarde) (Ontario Program for Optimal, 2001). Chez les populations qui passent d'un taux élevé à un faible taux de maladies infectieuses, comme les Autochtones du Canada, on assiste en général à une diminution du taux de maladies comme la cardiopathie rhumatismale, causée par une infection, mais aussi à une augmentation du taux de coronaropathie en raison des changements dans le mode de vie et les conditions socioéconomiques (Waldram et coll., 2006). Malgré l'intérêt qui existe pour la coronaropathie, ses causes et ses facteurs de risque, on n'a le plus souvent accès qu'à des données sur les maladies cardiovasculaires dans leur ensemble (Waldram et coll., 2006). C'est pourquoi la section qui suit portera sur la prévalence générale des maladies cardiovasculaires et, dans la mesure du possible, sur la coronaropathie.

3.2 Fardeau des maladies cardiovasculaires au sein des populations autochtones

Il a été établi que la prévalence de la coronaropathie diminue dans le monde occidental (Dorner et Rieder, 2004), mais cette diminution ne s'observe pas dans certains sous-groupes, comme les Autochtones du Canada. Traditionnellement, la prévalence de la coronaropathie est faible chez les Autochtones par rapport aux non-Autochtones (Anand et coll., 2001). Toutefois, les transformations politiques, économiques et sociales vécues récemment par de nombreuses communautés autochtones ont donné lieu à de grands changements dans leur alimentation et leur mode de vie – alimentation plus calorique et plus grande sédentarité, par exemple (Anand et coll., 2001) – qui ont contribué à faire augmenter la prévalence de la coronaropathie (Anand et coll., 2001; Shah, Hux et Zinman, 2000; Yusuf, Reddy, Ounpuu et Anand, 2001).

Le taux élevé de coronaropathie au sein des populations autochtones a été constaté pour la première fois dans des études nationales de la mortalité des membres des Premières nations au cours des années 1970 et 1980 (Waldram et coll., 2006). Ces études ont révélé que le taux de coronaropathie était plus élevé chez les femmes, mais pas chez les hommes (Mao, Moloughney, Semenciw et Morrison, 1992; Mao, Morrison, Semenciw et Wigle, 1986). En 1999-2000, le taux de mortalité normalisé selon l'âge s'est avéré un peu plus haut pour toutes les maladies cardiovasculaires, mais la différence entre les Premières nations et la population canadienne en général n'était pas statistiquement significative (Santé Canada, 2003; Waldram et coll., 2006). Cependant, la hausse de la prévalence de la coronaropathie chez les Autochtones du Canada a été nettement établie dans une étude réalisée auprès de 41 communautés ontariennes des Premières nations (Shah et coll., 2000). Cette étude a montré que le taux provincial d'admission à l'hôpital pour la coronaropathie avait plus que doublé au sein des 41 communautés – elle était passée de

76 pour 10 000 personnes en 1984 à 186 pour 10 000 en 1995 – tandis qu'il avait reculé dans le reste de la province (Harris et coll., 2002; Shah et coll., 2000). Parmi les résidents de Sandy Lake, l'admission à l'hôpital pour coronaropathie était passée de 34,8 à 109,1 pour 10 000 en 15 ans (Harris et coll., 2002). Une tendance parallèle a été constatée dans les taux d'admission pour un infarctus aigu du myocarde, ou crise cardiaque (Shah et coll., 2000). En outre, le taux d'infarctus aigu du myocarde au sein des Premières nations est environ 20 % plus haut que le taux canadien (Direction générale de la santé des Premières nations et des Inuits, 2000-2001).

Les données de 1981 à 1997 ont démontré que l'hospitalisation pour des maladies de l'appareil circulatoire a plus que doublé chez les Premières nations de l'Ontario pendant cette période (Shah, Hux et Zinman, 2000), ce qui donne à penser que ces maladies sont devenues une cause de morbidité plus importante. Cette hypothèse a été corroborée par les résultats de l'Enquête régionale sur la santé de 1997, selon laquelle les maladies du cœur et l'hypertension étaient respectivement trois fois et 2,5 fois plus fréquentes chez les Premières nations et les Inuits que dans la population canadienne en général (Centre des Premières nations, 2004). Qui plus est, l'Enquête régionale sur la santé de 2002-2003, qui a permis de recueillir les déclarations volontaires de troubles cardiaques chez les Premières nations, a mis en lumière une prévalence légèrement supérieure à celle de la population canadienne (7,6 % contre 5,6 %) (Centre des Premières nations, 2005). En tenant compte des groupes d'âge, il est ressorti que les adultes des Premières nations dépassaient grandement la moyenne canadienne : ceux de 50 à 59 ans avaient une prévalence de maladie cardiaque autodéclarée de 11,5 % par rapport à 5,5 % dans la population canadienne (Centre des Premières nations, 2005). Ces statistiques montrent que la coronaropathie menace de plus en plus les Premières nations du Canada, mais la prévalence des maladies cardiovasculaires, et plus précisément de la coronaropathie, dans les autres communautés autochtones est limitée (Métis) et non concluante (Inuits).

Il est difficile de saisir la question de la coronaropathie chez les Autochtones de l'Arctique parce que la documentation est contradictoire. Il est reconnu et signalé depuis longtemps que leur taux de coronaropathie est plus bas que dans la population en général (Bjerregaard et Dyerberg, 1988; Middaugh, 1990; Waldram et coll., 2006; Young et coll., 1993). La raison du taux moins élevé chez les Inuits que chez les Premières nations est souvent attribuée à l'éloignement : l'alimentation traditionnelle tirée des produits de la mer et le mode de vie ancestral serviraient de facteurs de protection (Dewailly et coll., 2001). Cependant, la fiabilité des statistiques sur la mortalité et des autres données utilisées pour ces études a été mise en doute (Bjerregaard, Young et Hegele, 2003). Il est par conséquent plus juste de dire que les données sur les taux de maladies cardiovasculaires dans les communautés du Nord et inuites ne sont pas concluantes. Selon Bjerregaard, Young et Hegele (2003), il faudrait réévaluer les données sur les maladies cardiovasculaires au sein des populations inuites ainsi que la protection qu'une alimentation traditionnelle peut fournir contre l'occidentalisation rapide et ses risques pour la santé.

Comme le montrent les questions soulevées par les statistiques sur les maladies cardiovasculaires chez les Inuits et comme c'est le cas pour tout ce qui touche la santé des Autochtones, il existe des différences sensibles dans les facteurs de risque et les taux de maladies entre les régions et les tribus. Les populations inuites et métisses sont d'importantes populations à cibler pour la recherche future, mais on peut en dire autant des communautés autochtones vivant en milieu urbain (Yusuf, Reddy, Ounpuu et Anand, 2001). En effet, la plupart des données actuelles sur les maladies cardiovasculaires portent sur les Autochtones des réserves, et l'on sait très peu de

choses sur le fardeau de ces maladies au sein des Autochtones hors réserve (Yusuf et coll., 2001). Il sera donc nécessaire d'effectuer des études qui ciblent tous les groupes d'Autochtones pour mieux comprendre le fardeau des maladies cardiovasculaires au sein des populations autochtones du Canada.

4. Fardeau des maladies respiratoires chroniques au sein des populations autochtones

4.1 Définition et description des maladies respiratoires chroniques

Pour la présente étude, les « maladies respiratoires chroniques » désignent tous les troubles respiratoires persistants ou récurrents liés aux voies respiratoires inférieures et supérieures (voies aériennes et autres structures pulmonaires). Parmi les maladies respiratoires chroniques les plus fréquentes, citons l'asthme, les broncho-pneumopathies chroniques obstructives, les allergies respiratoires, les pneumopathies professionnelles, les infections respiratoires chroniques, la tuberculose et l'hypertension pulmonaire (Organisation mondiale de la Santé, 2008).

Pour permettre des discussions constructives sur les infections respiratoires chroniques chez les Autochtones au Canada, cette section se limitera à cinq des principales maladies examinées dans la littérature et qui ont actuellement ou pourraient avoir des conséquences sérieuses pour la santé et le bien-être des Autochtones, soit 1) la tuberculose, 2) l'otite moyenne chronique, 3) les infections respiratoires chroniques ou récurrentes, 4) les broncho-pneumopathies chroniques obstructives, et 5) l'asthme. Mais avant, voici un bref survol des maladies respiratoires chroniques chez les Autochtones.

4.2 Fardeau général des maladies respiratoires chroniques au sein des populations autochtones

Même si les Autochtones ont rarement été touchés par les maladies respiratoires chroniques par le passé (Sin, Wells, Svenson et Man, 2002), ils le sont de plus en plus comparativement au reste de la population canadienne (Mao et coll., 1984; Mao et coll., 1992; Mao et coll., 1986; Morrison, Semenciw, Mao et Wigle, 1986; Young, 1983). Par exemple, les peuples autochtones risquent davantage de mourir d'une maladie respiratoire et d'accuser une morbidité excessive (Fraser-Lee et Hessel, 1994). Les enfants autochtones sont très à risque et souffrent beaucoup de maladies respiratoires : lors d'un sondage sur la santé des enfants autochtones, 13 des 20 répondants ont considéré les maladies respiratoires comme le principal problème de santé des enfants (Petersen, Singleton et Leonard, 2003). Une étude prospective sur les enfants nés en 1973 dans le Nord canadien indiquait que les maladies respiratoires étaient la cause de 36 % des décès et la première cause de la mortalité infantile (Orr, McDonald, Milley et Brown, 2001). Pire, le taux de mortalité infantile des Autochtones est deux fois plus élevé que la moyenne canadienne (Sin et coll., 2002).

4.3 Tuberculose

Maladie infectieuse chronique causée par des bactéries qui se propagent dans l'air, la tuberculose attaque habituellement les poumons (U.S. National Library of Medicine and the National Institutes of Health, 2005). Elle est considérée comme une maladie chronique, car les personnes atteintes demeurent infectées à vie. Depuis la mise au point d'un traitement (antibiotiques) et l'adoption de mesures de prévention (vaccins), on croit généralement que cette maladie est éradiquée. Malheureusement, c'est loin d'être le cas : environ 2 millions de personnes meurent

chaque année de cette maladie pourtant guérissable (Santé Canada, 2002) (Skeiky et Sadoff, 2006; Organisation mondiale de la Santé, 2005). Il n'est donc pas étonnant que les taux d'infection et de mortalité soient très élevés dans les pays en développement, où la pauvreté, le piètre accès aux soins de santé (ou leur absence) et les mauvaises conditions de vie sont choses courantes (Organisation mondiale de la Santé, 2005). Pour des raisons similaires, les Autochtones canadiens luttent encore contre cette maladie (Agence de la santé publique du Canada, 2002). Étant donné que la tuberculose est la première cause de mortalité chez les personnes atteintes du VIH ou du sida (Grange, Story et Zumla, 2001; Skeiky et Sadoff, 2006) et que le VIH et le sida menacent de plus en plus les peuples autochtones au Canada (Comité directeur national de l'Enquête sur la santé des Premières nations et des Inuits, 1999; Ring et Brown, 2002; Spittal et coll., 2002), on devrait continuer à concentrer les recherches futures sur les liens entre le VIH/SIDA et la tuberculose ainsi que sur leurs risques respectifs pour la santé (Santé Canada, 2002).

4.3.1 Fardeau de la maladie pour les adultes

La tuberculose a atteint des proportions épidémiques au sein des populations autochtones du Canada à la suite de leur contact avec les colons européens, soit du XVI^e au XX^e siècle (Hoeppner et Marciniuk, 2000). Selon l'Agence de santé publique du Canada (ASPC), l'incidence de la tuberculose continue à suivre la colonisation, qui se fait du sud vers le nord : les taux d'infection sont plus élevés dans les Prairies et le Nord, où les communautés autochtones ont eu des contacts plus tardifs avec les Européens que celles situées plus au sud (Agence de santé publique du Canada, 2002). Puisque la tuberculose a touché les Autochtones après les non-Autochtones, il n'est pas très étonnant que les Autochtones continuent souffrir davantage de la maladie (Gaudette et Ellis, 1993; Wang, Noertjojo, Elwood et FitzGerald, 2000). Par contre, le plus grand écart entre la prévalence de la tuberculose chez les Autochtones et chez les non-Autochtones est lui surprenant.

Depuis le début du XX^e siècle, le taux d'infection de la tuberculose a radicalement chuté au Canada, et il continue à baisser (Agence de santé publique du Canada, 2002; Wang et coll., 2000). Pourtant, le taux d'infection au sein des peuples autochtones n'a pas connu de baisse importante (Wang et coll., 2000) et il se situe maintenant bien au-delà de la moyenne canadienne (Young et Casson, 1988). En 1970, le taux d'infection était 12 fois plus élevé chez les Autochtones que chez les non-Autochtones, à savoir 212 cas par 100 000 habitants contre 17 cas; en 1995, le même taux était 39 fois plus élevé, soit 70 cas par 100 000 habitants contre 1,8 cas (Hoeppner et Marciniuk, 2000). Par ailleurs, afin de se faire une idée plus précise de la prévalence de la tuberculose chez les Autochtones, on a isolé la variable « ethnie » dans les données recueillies par Santé Canada entre 1990 et 2000. On a ainsi mis en évidence que le taux d'incidence chez les Autochtones, auparavant de 8 à 10 fois plus élevé, est maintenant de 20 à 30 fois plus élevé que la moyenne des non-Autochtones nés au Canada (Santé Canada, 2002).

Ces statistiques et d'autres chiffres étayant le lourd fardeau de la maladie au sein des peuples autochtones au Canada indiquent que la tuberculose demeurera une préoccupation à l'avenir (Smeja et Brassard, 2000). En 1999, parmi les nouveaux cas actifs et les cas de rechute signalés au Système canadien de déclaration des cas de tuberculose (SCDCT), 16 % étaient des personnes autochtones (Agence de la santé publique, 2002). Ce pourcentage est disproportionné étant

donné que les Autochtones ne représentent que 4,4 % de la population canadienne (Statistique Canada, 2003). En outre, 92 % des cas concernant les Autochtones sont nouvellement actifs : voilà une donnée très inquiétante sur la persistance et la présence de la maladie (Santé Canada, 2002). On note que les Autochtones atteints de la maladie sont sensiblement plus jeunes que les autres, ce qui est également préoccupant pour l'avenir. Nous allons maintenant examiner le fardeau de la tuberculose supporté par les enfants et les adolescents autochtones.

4.3.2 Fardeau de la maladie pour les enfants et les adolescents

En 2002, d'après Santé Canada, les jeunes adultes autochtones (âgés de 15 à 34 ans) étaient les plus susceptibles de souffrir de tuberculose infectieuse et les plus à risque de contracter la maladie (Santé Canada, 2002). Non seulement le taux était élevé chez les jeunes, mais la tuberculose était en 1999 29 fois plus fréquente chez les enfants autochtones que dans la population en général (Santé Canada, 2002). Même si ces données montrent une réduction du taux d'infection par rapport aux années antérieures (Santé Canada, 2002), leur gravité souligne l'ampleur des conséquences pour les générations plus jeunes.

On a constaté un bref plateau dans le taux d'infection au cours des années 1980; il s'agissait d'une anomalie par rapport à la tendance à la baisse observée au XX^e siècle. Pour enrayer cette prévalence persistante, on a alors commencé à administrer le vaccin BCG (bacille de Calmette et Guérin) aux nouveau-nés. Depuis, le BCG est devenu le vaccin le plus utilisé au monde même s'il a été prouvé que son efficacité est variable (0-80 %) (Andersen et Doherty, 2005). D'après des essais cliniques sur des animaux et des humains, ces variances sont causées par des réactions immunitaires préexistantes aux antigènes communs aux mycobactéries de l'environnement et de la tuberculose. Dans les communautés criées, le BCG est administré depuis 1982¹ (Smeja et Brassard, 2000). On n'a toujours pas démontré si le vaccin permettait de prévenir la tuberculose pulmonaire, mais les méta-analyses laissent entendre que son taux d'efficacité peut aller jusqu'à 80 % pour prévenir les formes graves de tuberculose chez les enfants (Colditz et coll., 1995). Aucune tuberculose progressive ni méningite tuberculeuse n'a été diagnostiquée chez les enfants criés depuis 1980, ce qui semble prouver les effets protecteurs du vaccin BCG (Smeja et Brassard, 2000). Cependant, on croit maintenant qu'il faudrait vacciner uniquement les nouveau-nés à haut risque, ce qui comprend beaucoup d'enfants en bas âge des populations autochtones et de mères séropositives (Colditz et coll., 1995; Menzies, Tannenbaum et FitzGerald, 1999).

4.4 Otite moyenne chronique

L'otite moyenne est une inflammation ou une infection de l'oreille moyenne causée par le blocage de la trompe d'Eustache (le passage de la gorge à l'oreille moyenne) (U.S. National Library of Medicine and the National Institutes of Health, 2005). Cette maladie est chronique ou aiguë, et suppurée ou séromuqueuse (Med-Help, 2005). La présente analyse portera essentiellement sur l'otite moyenne chronique puisqu'elle a pour but d'examiner les problèmes respiratoires chroniques des peuples autochtones au Canada. Lorsqu'on parlera d'otite moyenne chronique, il s'agira d'otite moyenne chronique suppurée puisqu'elle est la plus fréquente. Même si l'otite moyenne n'est pas généralement comprise dans les discussions sur les maladies

¹ De 1982 à 1989, on réadministrait le BCG à un enfant de un an si son résultat au test cutané à la tuberculine (TCT) annuel était inférieur à 5 mm; depuis 1989, le BCG est uniquement donné aux nouveau-nés.

respiratoires chroniques, elle est liée à une catégorie sous-estimée d'infections respiratoires chroniques d'origine bactérienne (Morris, 1998). Il est particulièrement indiqué d'en traiter ici en raison de sa prévalence chez les Autochtones, et parce qu'il est important de l'étudier dans le cadre d'une étiologie des maladies respiratoires.

L'otite moyenne chronique est provoquée lorsque le tube d'Eustache est bloqué à maintes reprises ou demeure bloqué pendant de longues périodes; elle peut donc être la conséquence d'une infection aiguë persistante de l'oreille ou d'autres infections répétées (U.S. National Library of Medicine and the National Institutes of Health, 2005). Des infections prolongées ou répétées peuvent endommager irrémédiablement l'oreille et ainsi causer une surdité partielle ou complète (Med-Help, 2005; U.S. National Library of Medicine and the National Institutes of Health, 2005). L'infection des oreilles est répandue chez les enfants : l'otite moyenne chronique se déclare habituellement chez le jeune enfant et persiste jusqu'à l'âge adulte (Med-Help, 2005), ce qui endommage considérablement l'oreille pour le reste de la vie.

Parce qu'elle est rare dans la majorité des pays développés, l'otite moyenne chronique suppurée est souvent qualifiée de maladie des pauvres (Coates, Morris, Leach et Couzos, 2002). L'Organisation mondiale de la Santé (OMS) a déterminé qu'une prévalence de l'otite moyenne chronique suppurée supérieure à 4 % constitue un « problème de santé publique à très grande échelle » (Organisation mondiale de la Santé, 1998). Au sein de nombreuses communautés et populations autochtones des régions circompolaires (Martin et Macdonald, 1998), le nombre d'enfants atteints est 10 fois plus élevé que la norme établie par l'OMS (Coates et coll., 2002). Dans les années 1960, afin de réduire la prévalence de cette maladie chez les Autochtones en Amérique du Nord, on a mis en place un programme de déclaration obligatoire des cas graves d'otite moyenne (Morris, 1998). De nos jours, il faudrait établir un programme de surveillance continue de cette maladie (Morris, 1998) puisqu'elle est endémique chez les enfants autochtones, métis et inuits du Nord canadien. En effet, on a parfois rapporté que le taux de prévalence dans ces communautés était jusqu'à 40 fois supérieur à celui des communautés urbaines non autochtones (Bowd, 2005).

La majorité des recherches sur l'otite moyenne chez les Autochtones ont été menées en Australie. Malgré des différences culturelles et géographiques évidentes entre les peuples autochtones du Canada et de l'Australie, on peut établir de solides parallèles entre leurs états de santé : les Autochtones du Canada et les Aborigènes de l'Australie souffrent de manière disproportionnée et comparable de cette maladie (Coates et coll., 2002), ce qui explique pourquoi les tendances observées en Australie sont pertinentes pour les Autochtones du Canada. Afin d'illustrer la prévalence de la maladie dans les communautés aborigènes australiennes, voici maintenant un survol de certaines études importantes réalisées dans ce pays. De telles études devraient être menées au Canada pour établir des statistiques exactes et utiles sur la situation des Autochtones.

En Australie, l'otite moyenne grave chez les enfants aborigènes vivant en milieu rural fait partie d'un éventail d'infections respiratoires chroniques d'origine bactérienne qui frappent les Aborigènes (Leach, 1999; Leach et Morris, 2001; Morris, 1998). En effet, les taux élevés d'otite moyenne chronique suppurée montrent bien le terrible fardeau que représente cette affection pour la santé des Aborigènes : 95 % des enfants aborigènes observés souffraient d'une otite moyenne, par rapport à 30 % des enfants non aborigènes (Boswell & Nienhuys, 1996).

La situation est encore pire dans les régions rurales et éloignées où cette maladie chronique touche presque tous les enfants (Leach, 1999). Dans une communauté aborigène rurale, on a diagnostiqué une otite moyenne aiguë chez tous les nourrissons de moins de trois mois; une étude de suivi a indiqué que la situation ne s'est pas résolue d'elle-même durant la petite enfance puisque 60 % des cas se sont transformés en otite moyenne chronique (Leach, 1999). Une étude faite dans la région des rivières du Nord (Nouvelles-Galles du Sud, en Australie) démontre encore plus clairement les répercussions à long terme de cette maladie. Dans cette région, 61,08 % des enfants observés montraient divers problèmes à l'oreille moyenne, 10,8 % souffraient d'une perte auditive unilatérale et 22,16 % d'une perte auditive bilatérale (Thorne, 2003). Comme les taux extrêmement élevés de surdité de transmission (supérieur à 50 %) qui en résultent ont souvent été associés aux problèmes scolaires des Aborigènes, cette maladie présente des problèmes physiologiques et sociologiques majeurs pour cette communauté.

Par ailleurs, l'Australia's National Trachoma and Eye Health Program (NTEHP) a fait ressortir la prévalence de la comorbidité de cette maladie dans la communauté aborigène (Moran, Waterford, Hollows et Jones, 1979) : l'otite moyenne était la maladie respiratoire d'origine bactérienne la plus diagnostiquée par les professionnels de la santé, et elle était associée à des taux extrêmement élevés de pneumonie, de méningite et de bronchiectasie chez les Aborigènes (Gandevia, 1967; Hanna et Torzillo, 1991; Maxwell, 1972; Torzillo et coll., 1995; Torzillo, Waterford, Hollows et Jones, 1983). Une corrélation analogue chez les Aborigènes de la Papouasie-Nouvelle-Guinée a déjà été documentée : l'infection précoce du nasopharynx et le haut taux de pneumonie étaient liés à la prévalence élevée de l'otite moyenne (Gratten et coll., 1986; Montgomery et coll., 1990).

Malgré les leçons que l'on peut tirer des recherches menées en Australie dans ce domaine, il est important de tenir compte des particularités du fardeau que représente l'otite moyenne chronique pour les populations autochtones du Canada. Des études ciblées doivent donc être planifiées pour évaluer l'incidence, la prévalence et le fardeau général de cette maladie.

4.5 Infections respiratoires chroniques ou récurrentes

Une infection respiratoire aiguë (Jacono, Jacono, Cano, Segami et Rubin, 1996) attaque les voies respiratoires inférieures ou supérieures, voire les deux. Elle peut être brève, persistante ou récurrente. Les infections respiratoires les plus fréquentes sont la bronchite, la bronchiolite, la pneumonie, la pneumonite et la diphtérie laryngienne (Kurzius-Spencer, Wind, Van Sickle, Martinez et Wright, 2005).

Pour des raisons pratiquement inconnues, les enfants autochtones sont plus susceptibles d'être atteints d'infections respiratoires (Evers, Orchard et McCracken, 1985; Harris, Glazier, Eng et McMurray, 1998; Orr et coll., 2001; Sin et coll., 2002) : plus de 90 % des enfants autochtones observés ont souffert d'une infection des voies respiratoires inférieures² au cours de leur première année de vie (Petersen et coll., 2003). Même si aucune comparaison avec une population caucasienne n'a été faite dans cette étude (Petersen et coll., 2003), d'autres ont démontré que les enfants aborigènes ont plus de troubles respiratoires que les autres. Par exemple, Evers et ses collaborateurs (Evers et coll., 1985; Evers & Rand, 1982, 1983), qui ont

² Une infection des voies respiratoires inférieures désigne la bronchite, la bronchiolite ou la pneumonie.

étudié de façon exhaustive les répercussions des infections respiratoires aiguës sur les Autochtones et les non-

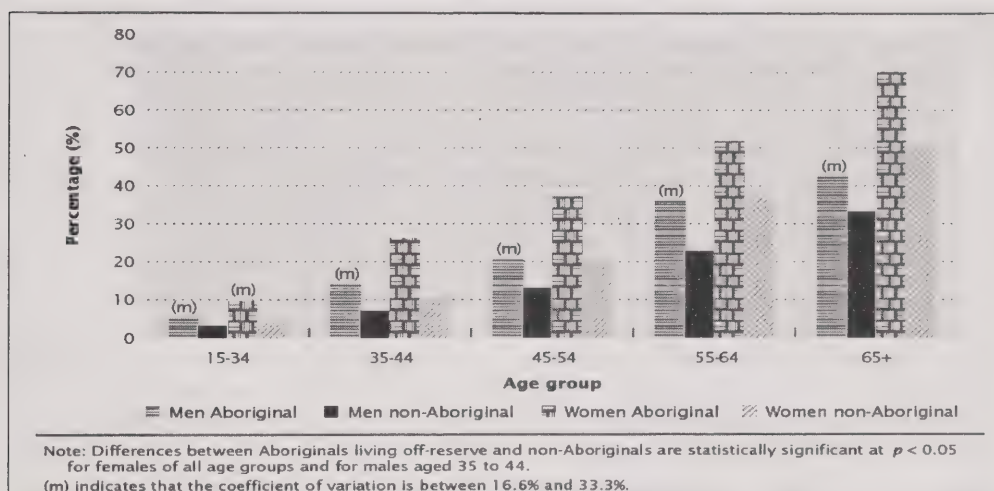
Autochtones dans le Sud-Ouest de l'Ontario, ont découvert qu'en dépit de la bonne situation socio-économique des communautés autochtones observées³, l'incidence des maladies des voies respiratoires inférieures est trois fois plus élevée chez les enfants des Premières nations que les autres (Evers et coll., 1985). Par ailleurs, une étude en population menée sur des nourrissons et jeunes enfants du Nord-Ouest de l'Ontario est parvenue aux mêmes conclusions : les infections respiratoires étaient la principale cause de maladie dans cette population, et les Autochtones étaient plus susceptibles de contracter des maladies respiratoires que les enfants non autochtones étudiés (Harris et coll., 1998). Plus précisément, l'incidence de la pneumonie des enfants de moins de deux ans était de 17 à 18 fois plus élevée chez les enfants autochtones que les autres (Evers et Rand, 1982, 1983). Comme les Inuits au Canada semblent être aussi susceptibles de souffrir de troubles des voies respiratoires inférieures, il est raisonnable de supposer que tous les Autochtones au pays risquent fortement de contracter une infection des voies respiratoires inférieures ou supérieures (Fraser-Lee et Hessel, 1994; Koch et coll., 2003).

La prévalence des infections respiratoires aiguës chez les enfants autochtones est inquiétante parce que ces infections peuvent se transformer en maladies chroniques : les infections respiratoires affaiblissent le système pulmonaire, ce qui peut endommager irrémédiablement les poumons et mener à des maladies chroniques (Anto, Vermeire, Vestbo et Sunyer, 2001). La tendance des enfants autochtones à souffrir de multiples pneumonies et bronchites montre bien que les Autochtones risquent que leurs infections respiratoires aiguës dégénèrent en maladies chroniques (Fraser-Lee et Hessel, 1994). Au cours des deux premières années de vie, les enfants autochtones sont souvent atteints de pneumonies et de bronchiolites, et fréquemment hospitalisés pour des complications respiratoires (Petersen et coll., 2003). Bien que leur situation s'améliore souvent après l'âge de deux ans, il a été démontré que la respiration sifflante récurrente et la toux chronique les suivent toute leur vie (Petersen et coll., 2003). Une récente étude sur les Autochtones de l'Alaska a prouvé l'existence d'une corrélation entre les infections et les maladies chroniques : 40 % des enfants étudiés ont montré des symptômes d'infections respiratoires et de maladies respiratoires chroniques (Lewis et coll., 2004). Une étude sur les jeunes enfants autochtones de la Nouvelle-Guinée a abouti aux mêmes constatations : on a établi un lien important entre la présence d'infections respiratoires précoces et l'apparition subséquente de l'asthme (Anderson, 1978).

³ Les communautés observées avaient des conditions de vie et un accès aux soins de santé bien supérieurs à ceux des autres communautés du Canada.

4.6 Broncho-pneumopathie chronique obstructive (BPCO) et asthme

Les symptômes de la broncho-pneumopathie chronique obstructive (BPCO) sont « l'essoufflement, la toux et la production d'expectorations » (Cardinal, 2004); à long terme, elle entraîne une diminution irréversible du volume expiratoire maximal par seconde (VEMS), une augmentation de la dyspnée et d'autres symptômes respiratoires, et une détérioration progressive de l'état de santé (Cardinal, 2004). Comme la BPCO a de grandes répercussions sur le système respiratoire, elle coïncide souvent avec d'autres maladies respiratoires, telles que la bronchite chronique, l'emphysème et l'asthme qui ont les mêmes symptômes et des interactions comorbides (Anto et coll., 2001). Toujours est-il qu'à elle seule, la BPCO est la première cause de mortalité et d'invalidité à l'échelle mondiale : entre 5 et 15 % des adultes des pays industrialisés en souffrent (Anto et coll., 2001), et ce pourcentage continue à augmenter. En 1990, la BPCO était la douzième cause connue de mortalité et d'invalidité combinées dans le monde : d'ici 2020, on s'attend à ce qu'elle grimpe au cinquième rang (Anto et coll., 2001). Par conséquent, elle nécessitera la mise en place de services de santé communautaires et hospitaliers complets au Canada.



Age group	Men Aboriginal	Men non-Aboriginal	Women Aboriginal	Women non-Aboriginal
Groupe d'âge	Hommes autochtones	Hommes non autochtones	Femmes autochtones	Femmes non autochtones

Source : (Canada 2003) Pourcentage : Pourcentage

Remarque : Les différences entre les Autochtones vivant hors réserve et les non-Autochtones sont statistiquement significatives ($p < 0,5$) pour les femmes de tous les groupes d'âge et les hommes de 35 à 44 ans. (m) indique que le coefficient de variation se situe entre 16,6 % et 33,3 %.

Même si les renseignements et les statistiques présentés ci-dessus nous aident à brosser un tableau du fardeau de l'arthrite au sein des populations autochtones, nous abordons brièvement

ci-après l'ostéo-arthrite pour mettre en lumière le fardeau particulier que fait peser ce type d'arthrite dans les populations autochtones et pour nous amener à discuter de l'ostéoporose.

Comme les symptômes, facteurs de risques et méthodes de traitement de l'asthme et de la BPCO sont souvent les mêmes (Anto et coll., 2001), ces deux maladies sont souvent regroupées. Cependant, il est important de distinguer ces deux maladies chroniques. Par définition, l'asthme est un trouble de la santé chronique caractérisé par une toux, un essoufflement, un resserrement de la poitrine et une respiration sifflante (Cardinal, 2004). De nos jours, l'asthme est la maladie chronique la plus fréquente chez les enfants (Lewis et coll., 2004), et les perspectives concernant cette maladie ne sont pas réjouissantes : la prévalence et la gravité de l'asthme infantile sont à la hausse, surtout chez les enfants de moins de cinq ans (Woolcock & Peat, 1997). L'asthme n'a pas affecté les Autochtones par le passé, mais sa prévalence croissante au sein des peuples autochtones aujourd'hui démontre que ces communautés y deviennent très vulnérables (Downs, Marks, Belosouva et Peat, 2001; Liu et coll., 2000; Sin et coll., 2002).

On a commencé à étudier la prévalence de l'asthme au sein des peuples autochtones du Canada depuis que Houston et ses collaborateurs (Houston, Weiler et MacKay, 1979) ont démontré une forte prévalence de la toux chronique et de l'épaississement des parois bronchiques chez les enfants autochtones, comparativement aux enfants blancs, dans le Nord de la Saskatchewan (Kurzius-Spencer et coll., 2005). De récentes études sur les Autochtones du Canada et des États-Unis ont montré qu'ils souffrent beaucoup de l'asthme (Lewis et coll., 2004; Liu et coll., 2000; Sin et coll., 2002) : au cours de leur première année de vie, les enfants autochtones sont hospitalisés deux à trois fois plus souvent que les autres enfants pour l'asthme (Lewis et coll., 2004; Liu et coll., 2000), et ils sont également plus hospitalisés pour des problèmes de respiration et de sifflement (Liu et coll., 2000; Sin et coll., 2002).

Au Canada, il faudra mener des recherches exclusivement sur les Autochtones afin d'adopter de nouveaux programmes et politiques pour réduire le fardeau de la BPCO et de l'asthme puisque des études déjà effectuées auprès des Autochtones révèlent qu'ils sont 2,1 fois plus susceptibles que les non-Autochtones d'âge et de sexe identiques de se rendre à une urgence hospitalière ou à une clinique médicale à cause de l'asthme (IC à 95 % : 2.0, 2.2) et 1,6 fois plus susceptibles de s'y rendre à cause de la BPCO (IC à 95 % : 1.6, 1.6) (Sin et coll., 2002). Par ailleurs, le fait que les Autochtones soient 55 % moins susceptibles que les non-Autochtones de consulter un spécialiste (IC à 95 % : 52, 58) et qu'ils soient 66 % moins susceptibles de subir une spirométrie (IC à 95 % : 63, 70) pour ces affections (Sin et coll., 2002) soulève de sérieux doutes sur la pertinence des politiques et des services de santé au Canada.

5. Fardeau des affections musculo-squelettiques au sein des populations autochtones

5.1 Définition et description des maladies et troubles musculo-squelettiques

Il a été établi que les maladies et troubles musculo-squelettiques sont la cause la plus commune de la douleur et de l'incapacité sévères (Lidgren, 2003). Voilà pourquoi, partout dans le monde, ils imposent un lourd fardeau aux sociétés de même qu'aux régimes de soins de santé (Lidgren, 2003). Au Canada, les maladies et troubles musculo-squelettiques représentent 10,3 % du fardeau économique total de la maladie, n'étant en cela dépassé que par les maladies cardiovasculaires (Canada, 2003, 2005; Lidgren, 2003). Le fardeau économique de ces maladies ne saurait faire autrement que de s'accroître avec l'augmentation de la population canadienne (Lidgren, 2003). Comme telles, les affections musculo-squelettiques représentent un sujet de discussion tout à fait opportun et pertinent. Il importe de se pencher sur l'incidence et la prévalence de ces maladies au sein des populations autochtones, car elles aussi vieillissent, et les maladies chroniques sont en voie de devenir une caractéristique plus importante de la santé autochtone.

Au moment d'entreprendre l'examen et la discussion du fardeau des maladies et troubles musculo-squelettiques au sein des populations autochtones, il importe de clarifier ce que ce titre recoupe. La classification des maladies et troubles musculo-squelettiques ayant changé avec le temps, il est difficile de déterminer la disponibilité et la fiabilité de l'information sur certains troubles et maladies (Jacobson, 1994). Par exemple, selon un rapport de l'OMS datant de 1989, on comptait alors plus d'une centaine de maladies et troubles du système musculo-squelettique; on les appelait les « maladies rhumatismales » et elles étaient caractérisées par l'inflammation des tissus conjonctifs, tout particulièrement les muscles, les articulations et les structures associées (Britannica, 2006; OMS, 1989). Toutefois, dans la classification moderne des maladies (CIM-10) il n'est plus question de « maladies rhumatismales »; les maladies et troubles musculo-squelettiques sont plutôt classés selon l'organe touché (CIM-10, 2006). Ou encore, certains chercheurs utilisent dans leurs études les critères de 1958 de l'ACR (anciennement, l'American Rheumatism Association), tandis que d'autres se servent des critères de 1987 de l'ACR. Bien qu'on en débâte encore, il semble que l'expression « maladies et troubles musculo-squelettiques » englobe près de 150 maladies et troubles différents (Lidgren, 2003).

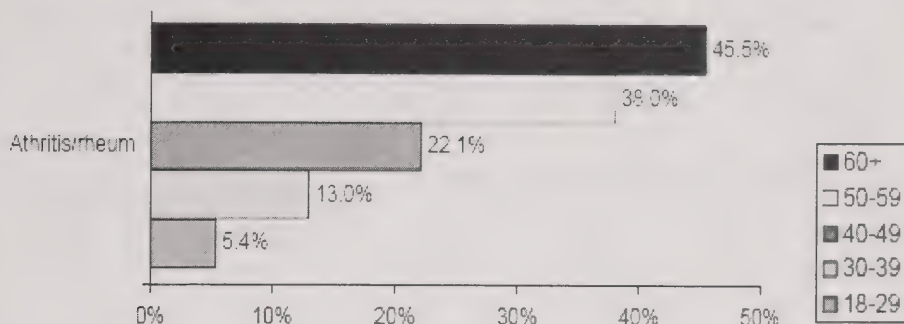
Parmi ces nombreux troubles et maladies, l'arthrite est la plus commune et la plus répandue. Fondamentalement, on entend par arthrite l'inflammation des articulations : du grec « arth », qui signifie articulation, et « itis », qui signifie inflammation (La Société de l'arthrite du Canada, 2004). Toutefois, ce serait par trop simplifier que de présumer que l'arthrite se résume à une affection, alors qu'en réalité on en dénombre bien des types différents (La Société de l'arthrite, 2004). Deux des affections arthritiques les plus communes sont la polyarthrite rhumatoïde et l'ostéo-arthrite ou arthrose (Canada, 2003; La Société de l'arthrite, 2004). Parmi les autres types communs d'arthrite dont il est question dans la littérature, mentionnons : les spondyloarthropathies et les arthropathies associées au lupus érythémateux disséminé et à la goutte (Canada, 2003). Bien qu'il existe de nombreux types différents d'arthrite, dans une grande partie de la littérature sur la prévalence des affections musculo-squelettiques, on se sert de la rubrique générale « arthrite/rhumatisme » : cette étiquette renvoie à l'ensemble des troubles douloureux des articulations qui vont de ceux qui sont liés à l'usure du cartilage (à savoir l'ostéo-arthrite) à ceux qui sont associés à l'inflammation qui découle d'une immunodéficience

(à savoir la polyarthrite rhumatoïde). Du fait de cette référence à deux volets, il est souvent difficile de distinguer ces deux affections. Comme tel, l'examen du fardeau de l'arthrite repose sur des renseignements généraux concernant les affections arthritiques chroniques (y compris la polyarthrite rhumatoïde). Toutefois, nous ne ferons pas du fardeau spécifique de la polyarthrite rhumatoïde un objet de discussion distinct de l'arthrite en général, parce que son étiologie est en grande partie inconnue et qu'elle résulte vraisemblablement d'une infection jugée évitable pour une bonne part et sans prédisposition à des facteurs de risque pendant le parcours de vie. En donnant ainsi à l'arthrite un sens plus large comme affection évitable, ce terme général devient plus approprié pour en discuter, tout comme l'est le fardeau spécifique de l'ostéo-arthrite (arthrose). Outre le fardeau général de l'arthrite et de l'ostéo-arthrite, on abordera également celui de l'ostéoporose. On traite souvent l'ostéoporose en même temps que l'arthrite parce qu'il s'agit là aussi d'une affection des os. Au lieu de l'inflammation caractéristique et des dommages aux articulations qui sont associés à l'arthrite, l'ostéoporose se caractérise par une masse osseuse très faible qui mène à un risque accru de fractures atraumatiques ou sous faible impact (Dictionnaire, 2002; CIM-10, 2006).

5.2 Fardeau de l'arthrite au sein des populations autochtones

Parmi la population canadienne en général, l'arthrite est l'une des affections chroniques les plus répandues et elle est la cause numéro un de l'incapacité et du recours aux soins de santé (Colombie-Britannique, 2001; Canada, 2003; OMS, 1989). L'arthrite a également été citée comme l'affection chronique la plus commune au sein de la population autochtone du Canada (Colombie-Britannique, 2001; Canada, 2003; La Société de l'arthrite, 2004; John, 2000; ERS, 2002-2003). Par exemple, il est ressorti d'une étude menée en Colombie-Britannique que l'arthrite était plus répandue parmi les Autochtones (17 %) que dans la population en général (5 %) (Canada, 2001). De la même façon, la prévalence de l'arthrite déclarée par les intéressés est également plus élevée au sein des populations amérindienne, esquimaude et aléoute (17,5 %), comparativement à la population blanche des États-Unis (15,2 %) (Lawrence, Deyo et Hochberg, 1998). Au Manitoba, l'arthrite rhumatoïde, l'arthrite dégénérative et d'autres formes d'arthrite non décrites ont été diagnostiquées par des médecins deux fois plus souvent chez des Manitobains appartenant à des Premières nations que chez des Manitobains non autochtones (Barnabe, Elias, Bartlett, Roos et Peschken, 2008). Comme l'arthrite comporte l'endommagement des articulations du corps, il n'est pas surprenant que cette affection ait tendance à s'accroître avec l'âge. La figure ci-après (Centre des Premières nations, 2005) montre l'augmentation importante de la répartition de l'arthrite parmi les adultes des Premières nations en fonction de l'âge.

Figure 1. Prévalence de l'arthrite parmi les adultes des Premières nations par groupes d'âge (rectifiée selon l'âge au total)



Source : (Centre des Premières nations, 2005).

Il a également été démontré dans des études que l'arthrite frappe beaucoup plus les femmes que les hommes. On la retrouve dans une proportion particulièrement élevée chez les femmes autochtones plus vieilles : ainsi, l'arthrite a été diagnostiquée chez 70 % des femmes âgées de 65 ans et plus, comparativement à 50 % chez les Canadiennes en général (La Société de l'arthrite, 2004). Bien que ces statistiques soient fondées sur des comparaisons entre la population canadienne et les femmes autochtones des réserves, la prévalence de l'arthrite épouse les mêmes tendances au sein de la population autochtone urbaine, vivant hors réserve (Canada, 2003).

5.2.1 Ostéo-arthrite

La forme d'arthrite la plus répandue est l'ostéo-arthrite, également appelée l'arthrose, l'arthrite dégénérative, la maladie dégénérative des articulations et l'arthrite de « l'usure ». Elle est causée par une rupture du cartilage qui recouvre les articulations et agit comme un coussin à l'intérieur de celles-ci, ainsi que par la destruction et la diminution du liquide synovial qui lubrifie ces articulations. Bien que l'ostéo-arthrite puisse affecter n'importe quelle articulation, elle se retrouve habituellement dans les articulations périphériques (c.-à-d. les hanches, les genoux, les mains et la colonne vertébrale) (Dictionnaire, 2002). Même si l'ostéo-arthrite est considérée comme largement héréditaire, on pense que les articulations vieillissantes, les blessures antérieures et l'obésité viennent en exacerber le risque.

Comme nous venons de le dire, l'ostéo-arthrite est la forme la plus commune d'arthrite; elle affecte 10 % de la population adulte canadienne (Canada, 2003). Bien que l'on dispose de peu de littérature sur l'ostéo-arthrite dans les populations autochtones, Thommasen (2006) a observé que les Canadiens et les Autochtones des régions rurales sont les plus susceptibles d'en être victimes (Thommasen, 2006). Des études de l'ostéo-arthrite menées antérieurement (1960-1961) chez les populations autochtones d'Amérique du Nord ont révélé que 68 % des Indiens Blackfoot, 65 % des Indiens Pima et 24 % des Inuits de l'Alaska souffraient de l'ostéo-arthrite des mains (Peschken et Esdaile, 1999). Ces taux sont particulièrement élevés quand on considère que la même étude a montré que de 7 à 12 % des populations blanches souffraient d'ostéo-arthrite en 1968 (Peschken et Esdaile, 1999). Une étude de 1986 a toutefois fait ressortir

des taux de prévalence de l'ostéo-arthrite beaucoup moins élevés chez les hommes inuits (1 %) et les femmes inuites (2 %) (Peschken et Esdaile, 1999). On a découvert que la prévalence de l'ostéo-arthrite de la hanche selon le sexe était la même dans les populations autochtones et non autochtones; elle est de moins de 10 % chez tous les groupes d'âge, hommes ou femmes (Hirsch, 1998). Chez les Aborigènes d'Australie, l'ostéo-arthrite semble particulièrement présente dans les articulations temporo-mandibulaires, le coude droit et les genoux (Roberts et Roberts-Thomson, 1999).

Comme ces données ne nous donnent qu'un aperçu superficiel du fardeau de l'ostéo-arthrite au sein des populations autochtones, il vaudra la peine de se pencher sur la littérature générale concernant l'arthrite et d'examiner la prévalence et le risque de l'arthrite, plus particulièrement de l'ostéo-arthrite, dans les populations autochtones.

5.3 Ostéoporose

L'Organisation mondiale de la Santé (OMS) définit et diagnostique ainsi l'ostéoporose chez les femmes : densité minérale osseuse (DMO) à 2,5 écarts-types en dessous du pic de la masse osseuse (moyenne chez les femmes en santé âgées de 20 ans) mesurée par absorptiométrie à rayons X en double énergie (DEXA) (Lewiecki, 2006; Organisation mondiale de la Santé, 1994); (Leslie, 2006; Skye Nicholas, 2002). Bien que ce test soit couramment utilisé, des chercheurs ont exprimé des doutes sur l'exactitude du diagnostic de l'ostéoporose parmi les enfants, les hommes et les femmes des autres groupes ethniques quand il est basé sur le critère de l'OMS (Skye Nicholas, 2002). On emploie l'expression « ostéoporose établie » pour parler de la présence accrue des fractures attribuables à la fragilité (Organisation mondiale de la Santé, 1994).

Dans l'ensemble, on dispose de peu de données sur l'ostéoporose dans les populations autochtones. Les études sur l'ostéoporose les plus facilement disponibles font état des taux de fracture ou s'y rapportent. Elles ne fournissent pas de données sur les valeurs moyennes de la densité minérale osseuse, également appelée teneur minérale de l'os (TMO) non plus qu'elles y font référence. Comme tel, il est difficile d'évaluer si les taux élevés de fracture dans ces populations sont liés à l'ostéoporose ou à d'autres facteurs, comme des activités à haut risque, des chutes dues à l'âge, des changements qualitatifs dans la structure des os, et des variations dans la géométrie des os (Skye Nicholas, 2002). Ces autres facteurs potentiels de fracture étant pris en compte, une étude rétrospective récente, basée sur la population et appariée par cohorte, des taux de fracture chez les populations autochtones et non autochtones du Manitoba a révélé parmi les Autochtones des taux plus élevés de fracture de la hanche, du poignet et de la colonne vertébrale que chez les non-Autochtones (Leslie, 2006). Les données de cette étude sont fournies dans le tableau ci-dessous.

Tableau 1. Taux de fracture chez les adultes, Autochtones et non-Autochtones du Manitoba (âgés de 20 ans et plus), 1984-2003

Foyer de fracture	Autochtones	Non-Autochtones
Hanche	1,1 %	0,6 %
Poignet	1,3 %	0,5 %
Colonne vertébrale	1,6 %	0,9 %

Source : (Leslie, 2006)

Comme il n'y a pas beaucoup d'information sur l'ostéoporose dans la population autochtone, il y aurait lieu de mener d'autres études pour dévoiler le fardeau sous-jacent de cette maladie parmi les Autochtones du Canada. L'existence possible de taux plus élevés d'ostéoporose dans les populations autochtones, qui seraient attribuables à des liens avec d'autres maladies chroniques et facteurs de risque, comme l'obésité et le régime alimentaire, fait de cette maladie un important secteur de recherche pour l'avenir.

6. Fardeau du cancer au sein des populations autochtones

6.1 Définition et description du cancer

Normalement, le corps humain est constitué de milliards de cellules qui se développent de façon prévisible. Le cancer intervient quand ces cellules commencent à se développer de manière imprévisible : il se caractérise par la croissance et la propagation incontrôlées de cellules anormales dans le corps (ASPC). Le cancer n'est pas qu'une seule maladie mais plus d'une centaine de maladies différentes et distinctes. Il peut toucher n'importe quel tissu de l'organisme et prend de nombreuses formes différentes dans chaque région du corps. La plupart des cancers sont désignés d'après le type de cellule ou d'organe dans lequel ils se développent en premier. La détection des cellules cancéreuses intervient le plus souvent quand celles-ci s'agglomèrent et forment une masse, couramment appelée une tumeur. À mesure que la tumeur prend de l'expansion, elle peut endommager et/ou remplacer les tissus voisins et métastaser (se répandre) dans une autre partie du corps (About.com, 2007).

L'essentiel de la documentation sur les taux de mortalité et d'incidence du cancer révèle que sa prévalence est moindre chez les Autochtones que parmi la population canadienne en général (Waldrum et coll., 2006). Parce qu'il est extrêmement difficile de déterminer la prévalence exacte du cancer parmi les populations autochtones, la fiabilité et l'exactitude des données statistiques actuelles sont limitées (Comité directeur national, Enquête régionale sur la santé des Premières nations et des Inuits, 1999). Cette considération étant prise en compte, dans la présente section on commence par décrire plusieurs des méthodes de surveillance utilisées pour examiner le cancer dans les populations autochtones. Suivra une présentation des données actuelles sur la prévalence du cancer.

6.2 Surveillance du cancer au sein des populations autochtones

Toutes les administrations provinciales canadiennes tiennent des registres du cancer fondés sur la population qui renferment des données sur le nombre des cas de cancer répertoriés au sein de leur population (Waldrum et coll., 2006). Le défi que pose la détermination de l'incidence et de

la prévalence du cancer au sein des populations autochtones tient au fait que la plupart de ces registres provinciaux ne présentent pas les données sur le cancer selon l'ethnicité (Comité directeur national, Enquête régionale sur la santé des Premières nations et des Inuits, 1999). En outre, Statistique Canada ne compile ni ne présente de données sur le cancer selon la situation ethnique (Waldram et coll., 2006).

Néanmoins, plusieurs méthodes de surveillance sont utilisées pour étudier le cancer dans les populations autochtones. Au nombre de ces méthodes, mentionnons : cueillette d'information à l'aide des codes de résidence pour les réserves; utilisation des indicateurs des Premières nations dans les numéros d'assurance-santé; utilisation de l'ethnicité consignée sur les certificats de décès, ou encore, établissement de liens entre les données et le Système de vérification de statut. Toutefois, le problème avec ces méthodes de surveillance est que dans les registres peuvent être incluses des personnes qui ne devraient pas y être et exclues des personnes qui devraient s'y trouver, ce qui donne des résultats biaisés (Marrett, Jones et Wishart, 2004). Par exemple, en utilisant les codes de résidence, on peut se trouver à inclure des non-Autochtones qui vivent dans les réserves, à exclure des Autochtones vivant en milieu urbain et d'autres Autochtones hors réserve, et à exclure également des personnes qui peuvent avoir été obligées de quitter leur communauté d'origine pour recevoir des traitements (Rosenberg et Martel, 1998). L'utilisation des numéros des cartes santé provinciales pose également problème parce que ces numéros ne comportent pas tous des indicateurs de Premières nations. Enfin, les données sur l'ethnicité des certificats de décès sont souvent consignées de façon inexacte et le Système de vérification du statut n'est pas toujours à jour (Marrett et coll., 2004). En raison de ces préoccupations, il serait bénéfique d'avoir d'autres méthodes pour étudier le fardeau des maladies au sein des populations autochtones, tout comme il le serait de créer des registres régionaux et/ou nationaux du cancer qui seraient particuliers aux Autochtones.

Un registre particulier a été créé; il s'agit du registre du cancer chez les Inuits du Canada, qui répertorie les cas recensés dans les Territoires du Nord-Ouest, au Nunavik et au Labrador (Gaudette et coll., 1996). Ce registre d'un caractère unique a été mis sur pied dans le cadre d'un examen circumpolaire international du cancer parmi les populations inuites (Gaudette et coll., 1996). Même si les Territoires du Nord-Ouest et le Nunavut ont tous les deux des registres courants pour le cancer, la tenue ou la mise à jour de ce registre des Inuits établi en collaboration ne se fait pas (Waldram et coll., 2006).

En conséquence, pour obtenir des données sur le fardeau du cancer au sein des populations autochtones il faut établir des liens entre les registres de l'ethnicité et les registres provinciaux. On obtient des données nationales en mettant ensemble les données provinciales. Comme ce système de rapport et ces sources de données posent problème, il est important d'examiner l'information obtenue par leur entremise. Avant d'aborder le fardeau du cancer au sein des populations autochtones, il importe d'expliquer qu'outre un système d'enregistrement défectueux, les quelques études canadiennes qui ont été publiées jusqu'ici sont restreintes quant à leurs généralisabilité et validité par-delà la source même de l'information. Marrett et Chaudhry (2003) ont bien résumé ces autres limites :

Au nombre des limites, mentionnons le petit nombre de cancers, les façons différentes d'identifier les cancers chez les gens des Premières nations par opposition aux groupes de la population en général, des numérateurs et dénominateurs tirés de sources

différentes, le caractère actuel déficient des données sous l'angle des années étudiées, et des populations restreintes (par exemple, seulement celles vivant dans les réserves). En outre, peu d'études présentent des chiffres et une période d'étude assez longue pour permettre d'examiner l'évolution dans le temps des tendances en matière de cancer (p. 259).

Compte tenu de ces limites et du fait qu'il n'existe qu'une poignée d'études publiées au Canada qui portent sur l'incidence du cancer et de la mortalité qui y est associée (Marrett et Chaudhry, 2003), nous tenterons dans la section suivante de résumer les renseignements généraux dont nous disposons sur le fardeau du cancer au sein des populations autochtones.

6.3 Fardeau du cancer au sein des populations autochtones

Bien qu'il n'y ait que très peu d'études sur le fardeau du cancer au sein des populations autochtones, la majorité d'entre elles portent sur les gens des Premières nations (Marrett et Chaudhry, 2003). Il existe également de l'information documentée sur la population inuite (Gaudette, Gao, Freitag et Wideman, 1993; Nielse, 1996) et même de l'information moins précisément ciblée sur la population métisse (Kliwer, Mayer et Wajda, 2002). En raison des différences qui existent sur les plans de la quantité de littérature et du fardeau de la maladie parmi les trois groupes différents d'Autochtones au Canada, nous allons les examiner séparément ci-après.

6.3.1 Fardeau du cancer parmi la population des Premières nations du Canada

Tous les sièges de cancer confondus (Waldram et coll., 2006), les données recueillies dans les années 1970 en Colombie-Britannique (Gallagher et Elwood, 1979), dans le Nord-Ouest de l'Ontario (Young et Frank, 1983) et au Manitoba (Young et Choi, 1985) révèlent toutes des taux d'incidence moins élevés dans les rangs des Premières nations. Toutefois, Rosenberg et Martel (1998), dans une étude ayant servi à examiner l'évolution chronologique de 1972 à 1976 et de 1987 à 1991, ont noté que l'incidence du cancer et de la mortalité qui y est associée semblaient s'accroître dans les réserves. Ils ont découvert que si l'incidence du cancer avait été traditionnellement plus faible au sein des populations des Premières nations, l'incidence en question ainsi que le profil de survie s'étaient révélés semblables à ceux de la population en général, exception faite d'une proportion plus élevée de cas et de mortalité attribuables au cancer du col de l'utérus et de la vésicule biliaire chez les femmes et du cancer du rein chez les hommes et les femmes (Rosenberg et Martel, 1998). Marrett et Chaudhry (2003) ont signalé des tendances semblables dans leur étude de l'incidence du cancer et de la mortalité associée parmi les gens des Premières nations de l'Ontario entre 1968 et 1991. Dans le cas de certains des cancers les plus fréquents (à savoir le cancer du sein, des poumons, de la prostate et colorectal), Marrett et Chaudhry, 2003, ont déterminé que l'incidence était sensiblement moins élevée chez les Indiens inscrits, par rapport à la population en général. En dépit de ces taux comparativement moins élevés, les taux d'incidence dans le cas de tous les types de cancer ont augmenté de façon significative au cours des périodes de temps étudiées. Faisaient exception à cette tendance d'autres cancers moins répandus comme le cancer du col de l'utérus, de la vésicule biliaire et du rein : le cancer de la vésicule biliaire est deux fois plus courant chez les Indiens et Indiennes inscrits que dans la population en général; le cancer du col de l'utérus est 1,73 fois plus élevé chez les Indiennes inscrites que dans la population en général et arrive au deuxième rang au chapitre de la prévalence parmi les Indiennes; quant au cancer du rein, il apparaît moins fréquent

chez les populations d'Indiens inscrits, mais le taux pour les deux sexes n'était pas statistiquement significatif (Marrett et Chaudhry, 2003). Le tableau ci-après résume ces données et d'autres renseignements clés recueillis dans l'étude de Marrett et Chaudhry (2003); on y fait également une comparaison sommaire avec les autres grandes études menées dans les provinces pour l'ensemble du pays.

Tableau 2. Cancer : incidence, prévalence et mortalité en Ontario, au Manitoba, en Saskatchewan et en Colombie-Britannique

Province	Littérature connexe	Cancer : incidence, prévalence et mortalité
Ontario	(Marrett et Chaudhry, 2003; Young et Frank, 1983)	<ul style="list-style-type: none"> • L'incidence des cancers du rein, de la bouche, de la gorge et de l'estomac est semblable chez les populations autochtones et non autochtones des deux sexes; • L'incidence du cancer colorectal est équivalente chez les populations mâles autochtones et non autochtones; • En ce qui a trait aux cancers les plus répandus (sein, prostate, poumons et colorectal), chez les populations autochtones l'incidence s'accroît et se rapproche des taux de cancer pour l'ensemble de l'Ontario; • L'incidence du cancer du col de l'utérus diminue chez les femmes autochtones et s'approche du taux de l'ensemble des femmes de l'Ontario; • Comparativement à la population non-autochtone, les taux de survie sont nettement moins élevés dans les populations autochtones pour ce qui est de tous les cancers réunis, du cancer de la prostate chez les hommes autochtones et du cancer du sein chez les femmes autochtones; • Dans le cas des autres cancers les plus répandus (poumons, colorectal et col de l'utérus) les taux de survie sont semblables chez les populations autochtones et non-autochtones.
Manitoba	(Young et Choi, 1985)	<ul style="list-style-type: none"> • L'incidence du cancer du col de l'utérus est plus élevée chez les femmes autochtones que chez les femmes non autochtones; • L'incidence du cancer du rein est plus élevée dans la population autochtone.

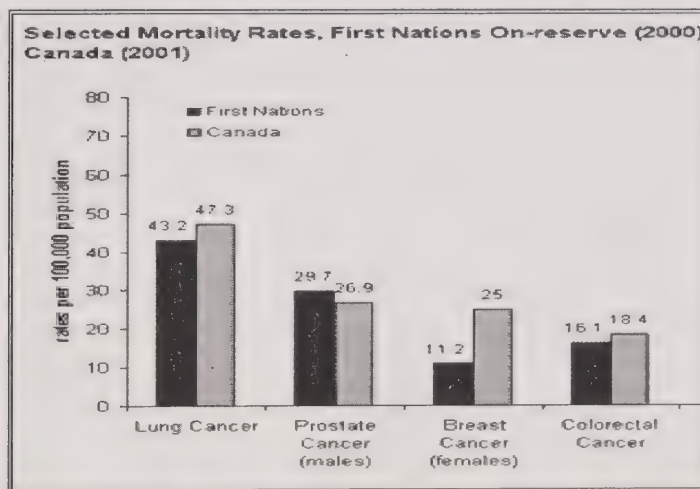
Saskatchewan	(Gillis et coll., 1991)	<ul style="list-style-type: none"> Le taux de survie au cancer du sein est moins élevé dans la population autochtone du Nord que dans la population non autochtone du Sud.
Colombie-Britannique	Threlfall et coll., 1986	<ul style="list-style-type: none"> L'incidence du cancer du col de l'utérus est plus élevée chez les femmes autochtones que chez les femmes non autochtones; Les taux d'incidence du cancer du pancréas et de l'estomac dans la population autochtone sont semblables à ceux de la population de la C.-B.; Les taux de survie, tous les cancers confondus, sont semblables dans les populations autochtones et non autochtones.

Information provenant de (Marrett et Chaudhry, 2003).

Comme le tableau l'indique, la quantité et le genre de renseignements disponibles dans chaque province varient beaucoup.

Dans une tentative pour obtenir une perspective nationale, Statistique Canada a comparé en 2000 et 2001 les taux de mortalité associés aux principaux cancers chez les Premières nations des réserves et la population canadienne en général. Ces analyses ont révélé que sauf pour le cancer de la prostate, les taux de mortalité par cancer chez les Premières nations étaient moins élevés que dans la population canadienne en général (Statistique Canada). La figure ci dessous en témoigne.

Figure 3. Taux de mortalité choisis, Premières nations des réserves et Canada



(Statistique Canada)

Bien que ces taux plus faibles soient encourageants, la littérature examinée ci-dessus indique que les taux de cancer augmentent chez les populations des Premières nations et se rapprochent rapidement de ceux de la population canadienne en général (Marrett, 2003).

6.3.2 Fardeau du cancer parmi la population inuite du Canada

Le fardeau de la maladie parmi la population inuite du Canada est plutôt différent de celui qui a été noté chez les Premières nations du Canada. Par exemple, dans le cas de plusieurs cancers rares, notamment le cancer du nasopharynx, des glandes salivaires et de l'œsophage (Gaudette et coll., 1993; Waldram et coll., 2006), il a été noté que les Inuits étaient à haut risque. Depuis les années 1970, toutefois, ces « cancers inuits traditionnels » (Waldram et coll., 2006) ont diminué, tandis que les cancers plus répandus parmi la population en général, comme le cancer des poumons, du col de l'utérus, du colon et du sein, ont augmenté (Hildes et Schaefer, 1984; Schaefer, Hildes, Medd et Cameron, 1975).

Les données sur le cancer recueillies au cours de la période de 1969 à 1988 au Groenland, au Canada et en Alaska nous donnent des aperçus importants des profils des cancers à l'étude chez les populations inuites circumpolaires (Nielse, 1996). Par exemple, les résultats de cette étude internationale faite en collaboration montrent que de 1969 à 1988, les taux standardisés pour l'âge ont augmenté de 22 % dans le cas des hommes autochtones et de 24 % dans le cas des femmes autochtones, ce qui ne s'écarte pas de façon significative des taux de cancer observés dans la population en général au Canada, au Danemark et au Connecticut (États-Unis) (Nielse, 1996). Toutefois, on a découvert des différences importantes entre les populations inuites et les populations mises en comparaison en ce qui a trait aux taux relatifs à des cancers en particulier. Comparés aux populations du Canada, du Danemark et du Connecticut (États-Unis), les Inuits sont à plus haut risque en matière de cancer du poumon, du nasopharynx, des glandes salivaires, de l'œsophage, de la vésicule biliaire et du canal cholédoque extrahépatique. Les hommes inuits ont un taux d'incidence plus élevé dans le cas du cancer du foie et de l'estomac, tandis que les femmes inuites sont à plus haut risque en ce qui concerne le cancer du col de l'utérus et du rein. Les principaux foyers de cancer chez les hommes et les femmes inuits des pays circumpolaires sont présentés au tableau 3 ci-dessous.

Tableau 3. Les principaux foyers cancéreux chez les Inuits des pays circumpolaires (1969-1988)

Principaux foyers cancéreux chez les Inuits des pays circumpolaires (1969-1988)				
Hommes			Femmes	
1	Poumons	28,3 %	Col de l'utérus	17,6 %
2	Colon	8,1 %	Poumons	13,7 %
3	Estomac	7,0 %	Sein	11,4 %
4	Nasopharynx	6,5 %	Colon	9,6 %

(Nielse, 1996)

Dans le cas de certains cancers, les populations inuites circumpolaires subiraient des taux élevés; par contre, elles sont à plus faible risque dans le cas du cancer de la vessie, du sein, de l'endomètre, de la prostate, ainsi que dans le cas des lymphomes, de la maladie de Hodgkin, de

la leucémie, du myélome multiple et du mélanome (Nielse, 1996). Dans le cadre de futures recherches, il sera important de se pencher sur les raisons qui sous-tendent les différences de prévalence parmi les Inuits.

6.3.3 Fardeau du cancer parmi la population métisse du Canada

On dispose de très peu d'information sur l'état de santé des Métis du Canada, tout particulièrement en ce qui a trait au cancer. Afin de trouver des façons de développer un bassin de renseignements sur le fardeau du cancer parmi la population métisse du Manitoba, la Manitoba Métis Federation (MMF) s'est adressée à CancerCare Manitoba pour discuter des possibilités de partage d'information et de développement d'une base de données (Kliwer et coll., 2002). Comme nous l'avons dit au début de cette section, les bases de données tenues par les organisations provinciales ne comportent pas d'indicateurs particuliers de nature ethnique ou raciale (Comité directeur national, Enquête régionale sur la santé des Premières nations et des Inuits, 1999). On a procédé à une étude pilote pour évaluer la faisabilité de lier un échantillon de la liste des membres de la MMF aux bases de données de Santé Manitoba (la base de données provinciale) et de CancerCare Manitoba, afin de pouvoir retrouver des renseignements plus concrets sur l'état de santé des Métis (Kliwer et coll., 2002). Comme les données utilisées pour calculer la prévalence du cancer dans le cadre de cette étude ne sont pas très nombreuses, il n'est pas possible de présenter des rapports détaillés sur les foyers de cancer. On peut toutefois à partir de cette étude (Kliwer et coll., 2002) faire certaines observations préliminaires au sujet du fardeau du cancer chez les Métis du Manitoba.

Parmi l'échantillon de l'étude, de 1995 à 1997, on a diagnostiqué le cancer chez six (6) hommes et vingt (20) femmes. Dans l'ensemble, cela signifie que le taux d'incidence moyen annuel du cancer standardisé pour l'âge était moins élevé chez les hommes métis que dans l'ensemble de la population mâle du Manitoba. Dans le cas des femmes métisses, l'incidence était légèrement plus élevée que pour l'ensemble des femmes du Manitoba. Il a été établi que le taux de cancer du col de l'utérus était sensiblement plus élevé parmi les femmes métisses. Les taux de prévalence bruts standardisés pour l'âge étaient plus faibles dans le cas des femmes métisses. Toutefois, quand on a tenu compte des taux de prévalence spécifiques à certains âges, la prévalence était plus élevée pour les femmes métisses que pour l'ensemble des femmes du Manitoba. La prévalence des tumeurs malignes et d'autres néoplasmes était plus faible chez les hommes métis que dans la population en général, tandis que les tumeurs malignes affichaient des taux plus élevés chez les femmes métisses et que les taux des autres néoplasmes étaient comparables à ceux de la population manitobaine féminine en général. Cette prévalence globale élevée du cancer chez les femmes métisses est attribuée aux taux sensiblement plus élevés du cancer du col de l'utérus chez elles, comparativement aux femmes du Manitoba. Ces données se comparent à celles d'études du cancer du col de l'utérus établies pour les Indiens inscrits visés par un traité du Manitoba (Young, Kliwer, Blanchard et Mayer, 2000).

Bien que ce bref survol des taux de cancer parmi les Métis du Manitoba permette de commencer à tracer un portrait du fardeau du cancer parmi les Métis, ses limites en tant qu'étude pilote et sa portée provinciale font ressortir qu'il nous faut davantage de renseignements et de données.

7. Fardeau des maladies mentales graves dans les populations autochtones

7.1 Définition et description de « maladie mentale chronique »

Les maladies mentales ont été définies comme étant des « états de détresse résultant d'interactions complexes entre une personne et son environnement au cours de décennies du développement personnel » (Spaulding, Sullivan et Poland, 2003). Cependant, le caractère chronique des maladies mentales suscite bien des débats. Cela est en grande partie attribuable à la définition même de « chronicité ». Par exemple, est-ce que chronicité renvoie à la durée des symptômes, à l'incapacité fonctionnelle qui résulte de la maladie mentale ou aux deux? (Bachrach, 1988; Soreff, 1996.) Si cela renvoie aux deux, est-ce que la durée et l'incapacité sont aussi importantes l'une que l'autre dans la détermination de la chronicité? De plus, est-ce que la chronicité est déclarée après une durée spécifique d'une maladie persistante ou après un certain nombre d'épisodes itératifs (Soreff, 1996)? Il y a également la question de savoir si la chronicité peut être déduite de diagnostics de troubles mentaux spécifiques (Bachrach, 1988). Quoi qu'il en soit, les chercheurs s'entendent généralement à dire qu'un diagnostic est « nécessaire, mais pas suffisant pour déclarer qu'il y a une maladie mentale chronique » (Bachrach, 1988).

Des intervenants du domaine de la santé mentale sont préoccupés par l'utilisation du mot « chronique » parce qu'ils estiment qu'il perpétue l'idée que la maladie ne peut être ni gérée ni traitée (Bachrach, 1988). Déclarer une personne atteinte d'une maladie mentale chronique pourrait donner l'impression que cette personne sera malade toute sa vie (Bachrach, 1988; Lefley, 1990; Soreff, 1996). Afin d'éviter le stigmate associé au mot « chronique », on utilise couramment l'expression « maladie mentale grave et persistante », ou simplement « maladie mentale grave », expression que nous utiliserons ici.

En dépit des nombreux défis que pose la définition de « maladie mentale grave », des chercheurs s'y sont essayés. Stein (1995) a défini l'expression comme étant « les maladies qui durent plus d'un an, entraînent un dysfonctionnement majeur et correspondent à certains critères diagnostiques ». Pour leur part, Rosenberg et ses collègues (2005) ont défini l'expression comme étant « un diagnostic de maladie mentale grave, d'incapacité dans des activités importantes de la vie (par ex. à l'école, au travail ou dans la vie familiale), avec persistance de la maladie et incapacité ». Soreff (1996) en donne cette définition, qui est plus large : « incapacités graves et persistantes résultant principalement de la maladie mentale », tout en reconnaissant les grandes différences dans la durée de la maladie et le degré d'incapacité qui influencent le diagnostic. En fait, « on retrouve aujourd'hui chez les personnes que l'on pourrait dire atteintes d'une maladie mentale chronique un large éventail de diagnostics, de traitements, de niveaux de fonctionnement et de besoins de traitement » (Bachrach, 1988). Il sera important de tenir compte de ces différences dans l'examen du fardeau que représentent les maladies mentales graves au sein des populations autochtones parce que la littérature limitée sur les maladies mentales au sein de ces populations et les contextes restreints dans lesquels elles ont été examinées peuvent conduire à une généralisation abusive des constatations et ne donner qu'une image bien incomplète de la situation.

7.2 Fardeau des maladies mentales graves au sein des populations autochtones

En dépit des divergences de vues sur ce qui constitue un trouble mental grave et persistant, la schizophrénie, le trouble bipolaire et le trouble dépressif grave sont généralement classés dans

cette catégorie (Bachrach, 1988; Rosenberg et coll., 2005; Stein, 1995). Par conséquent, ces troubles doivent être inclus dans les maladies mentales graves qui affectent les Autochtones. Malheureusement, les rares travaux de recherche sur le trouble bipolaire au sein des peuples autochtones limitent notre capacité de discuter du sujet. Cela démontre clairement qu'il serait utile de faire des recherches sur le sujet. Quoi qu'il en soit, nous aborderons ici la schizophrénie, le trouble dépressif grave, le trouble de stress post-traumatique et les toxicomanies au sein des populations autochtones. Dans toute la mesure du possible, nous utiliserons la littérature sur la situation au Canada, mais puisqu'il existe peu d'études portant spécifiquement sur la santé mentale des populations autochtones canadiennes nous utiliserons des études portant sur des populations autochtones non canadiennes. Nous pouvons tirer des leçons importantes pour le contexte canadien dans les études sur la prévalence, le fardeau et le traitement des maladies mentales graves faites auprès de populations étrangères semblables aux populations canadiennes.

7.2.1 Schizophrénie

Les premières études sur la schizophrénie révèlent des différences dans l'incidence et l'expression des symptômes chez les Autochtones et les non-Autochtones. Bates et Van Dam (1984), par exemple, ont constaté une incidence de la schizophrénie beaucoup plus faible chez les Premières nations de la côte de la Colombie-Britannique que chez les caucasiens, quoique les taux d'incidence variaient d'une population autochtone à l'autre. Mowry et ses collaborateurs (1994) ont constaté que, chez les personnes qui ont reçu un diagnostic de schizophrénie dans l'Ouest de l'Australie, les symptômes consignés dans les dossiers médicaux étaient très différents selon qu'il s'agissait d'Aborigènes ou de non-Aborigènes. Les auteurs donnent diverses explications possibles dont : une mauvaise interprétation des symptômes par les professionnels de la santé; un biais dans les examens cliniques et la tenue des dossiers; une manifestation particulière de la schizophrénie chez les Aborigènes; des erreurs de diagnostic chez les patients aborigènes atteints d'autres maladies mentales (Mowry et coll., 1994).

Les travaux de recherche récents sur la schizophrénie au sein des populations autochtones sont limités. Cependant, les études qui existent contredisent et confirment simultanément les anciens travaux de recherche sur le sujet. En Nouvelle-Zélande, des chercheurs ont mentionné que les Maoris étaient surreprésentés parmi les adolescents qui rapportaient eux-mêmes des symptômes schizotypiques (c'est-à-dire pensée magique, tendance aux hallucinations, idéation autoréférentielle et aberrations dans la perception) (Linscott, Marie, Amott et Clark, 2006). Par contre, Robin et collaborateurs (2007) rapportent que la prévalence de la schizophrénie chez deux tribus indiennes nord-américaines était égale à la prévalence dans la population en général, tandis que cette prévalence était inférieure à ce que l'on prévoyait chez les parents au deuxième degré de schizophrènes. Les auteurs reconnaissent que la prévalence de la schizophrénie n'était pas plus élevée dans ces tribus en dépit du risque accru attribuable à leur taux élevé de consommation d'alcool et de drogue et à leur situation socio-économique déplorable. Ils arrivent à la conclusion que les erreurs de diagnostic psychiatrique, la taille réduite des échantillons et une méconnaissance du contexte culturel ont conduit à une surévaluation de la prévalence de la schizophrénie parmi les Indiens d'Amérique du Nord (Robin et coll., 2007). Par conséquent, il faut tenir compte de facteurs socio-culturels avant de faire un diagnostic de schizophrénie (Robin et coll., 2007). Il est donc clair qu'il n'y a pas un taux unique de prévalence de la schizophrénie pour tous les groupes autochtones. Lorsque l'on constate des écarts des taux de prévalence par

rapport aux populations non autochtones, ces écarts s'expliquent moins par des différences biologiques que par des différences culturelles.

Comme nous venons de le démontrer, il faut davantage de travaux de recherche ciblés sur la schizophrénie dans le contexte canadien. En outre, il serait utile de faire de la recherche sur le traitement, les interventions possibles et les moyens d'améliorer la santé et le bien-être des schizophrènes.

7.2.2 Dépression

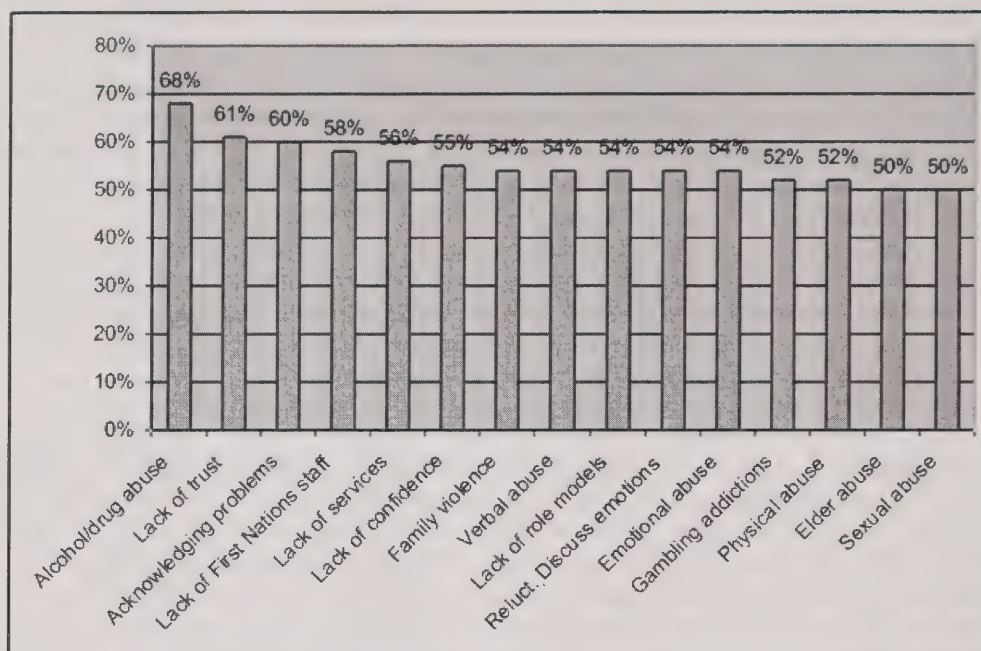
La question de savoir si la dépression est une maladie chronique ou pas fait l'objet d'un débat (Gask, 2005; Parker, 2005; Van Weel-Baumgarten, 2005). « Dépression » et « dépression grave » sont des termes qui simplifient à outrance et dissimulent la multiplicité des causes, des manifestations, de l'évolution et des résultats des différents troubles dépressifs existants (Parker, 2005). Étant donné l'effet que les antécédents d'un patient, sa recherche d'aide, son milieu social et son adhésion au traitement de même que la compétence du professionnel de la santé, ses priorités, ses préjugés et ses méthodes de traitement préférées peuvent avoir sur la réaction du patient au traitement, on pourrait soutenir avec raison que, chez certains, la dépression est chronique tandis qu'elle ne l'est pas chez d'autres (Van Weel-Baumgarten, 2005).

On suppose souvent que la dépression est prévalente parmi les peuples autochtones en raison des taux de suicide élevés dans certaines communautés (Thommasen, Baggaley, Thommasen et Zhang, 2005), mais les signalements d'épisodes dépressifs chez les Autochtones varient considérablement. En outre, les signalements de cas de dépression chez les Autochtones du Canada sont presque exclusivement limités aux Premières nations, et il existe peu de données sur les Métis, les Inuits et les Autochtones non inscrits (Conseil canadien de la santé, 2005). Même les données dont nous disposons sur les Premières nations proviennent d'auto-signalements lors de sondages et ne donnent donc qu'une estimation brute des taux de dépression sans fournir d'information sur des troubles mentaux spécifiques. Afin de tenter de mieux comprendre le phénomène de la dépression chez les Autochtones, nous passerons maintenant en revue la littérature canadienne et étrangère disponible sur le sujet.

L'Enquête sur la santé dans les collectivités canadiennes pour 2000-2001 révélait que 13,2 % des Autochtones canadiens hors réserve avaient connu un épisode de dépression grave au cours de l'année écoulée, soit 1,8 fois le taux de la population non autochtone. Cependant, les taux étaient identiques chez les Autochtones et les non-Autochtones vivant dans les territoires canadiens et chez les ménages à revenu faible ou élevé (Tjepkema, 2002). Une autre enquête canadienne, l'Enquête nationale sur la santé de 2002-2003, révélait que, chez les membres des Premières nations ayant répondu au questionnaire, 30,1 % des adultes et 27,2 % des jeunes s'étaient sentis tristes ou déprimés pendant au moins deux semaines au cours de l'année ayant précédé l'enquête (Centre des Premières nations, 2005). Ces gens rapportaient deux fois plus d'idées suicidaires et de tentatives de suicide que ceux qui ne s'étaient pas sentis tristes ou déprimés. Des travaux de recherche effectués par le gouvernement du Canada ont révélé qu'environ 8 % des adultes canadiens connaissent une dépression grave à un moment ou à un autre de leur vie (Santé Canada, 2002) comparativement à 12 % (2001) pour les Premières nations (gouvernement du Canada, 2006). Une étude exhaustive sur la dépression, l'anxiété et l'utilisation d'antidépresseurs dans la vallée Bella Coola, en Colombie-Britannique, a fait ressortir un taux de prévalence de la dépression et des troubles de l'anxiété très légèrement inférieur chez les

Autochtones par rapport aux non-Autochtones (Thommasen et coll., 2005). Cependant, dans d'autres études, on n'a relevé aucune différence statistiquement importante des taux de dépression chez les Autochtones et les non-Autochtones (Thommasen, Baggaley, Thommasen et Zhang, 2005). Par contre, une étude menée aux États-Unis a révélé que les Indiens des plaines du Nord et des tribus du Sud-Ouest étaient moins exposés que les personnes d'un échantillon de la population générale à des épisodes dépressifs de 12 mois ou de toute la vie, mais cette étude a fait ressortir des écarts importants entre les deux tribus et entre les hommes et les femmes (Beals, Novins, Spicer, Mitchell et Manson, 2005). Dans un échantillon d'Indiens navajos, 37 % avaient connu un épisode dépressif majeur au cours de leur vie, 11 % rapportaient avoir, au moment de l'étude, des troubles dépressifs et 20 % avaient connu une dépression, des troubles de l'anxiété et des abus d'intoxicants au cours de leur vie (Storck, Csordas et Strauss, 2000). Les écarts qui existent dans les expériences de la dépression parmi les peuples autochtones donnent à entendre que, comme dans la population en général, la dépression sera chronique chez certaines personnes et pas chez d'autres.

Des travaux de recherche canadiens ont porté sur la manifestation de la dépression chez les peuples autochtones. Kirmayer et ses collaborateurs (1994) signalaient pour les Inuits du Nunavik des symptômes éprouvés lors d'épisodes dépressifs correspondants aux critères diagnostiques de la CIM-10 : désir d'être seul, refus de parler aux autres, perte d'appétit, insomnie et crises de larmes fréquentes. Söchting, Corrado et leurs collaborateurs (2007) ont constaté que les symptômes des Autochtones ayant recours aux services de santé mentale, comme la difficulté d'établir des relations interpersonnelles, une piètre image de soi, l'incapacité de réfréner et de contrôler les émotions négatives intenses et les abus d'intoxicants, étaient souvent extrêmes (Söchting et coll., 2007). Certains ont avancé que les moyens traditionnels de surmonter le stress et la détresse psychologique avaient récemment été remplacés par des comportements impulsifs et l'abus d'intoxicants (Kirmayer et coll., 1994). Beaucoup d'hommes autochtones évitent les services médicaux et tentent de surmonter leur dépression par la consommation d'alcool et la chasse (gouvernement du Canada, 2006; Kirmayer et coll., 1994). Chez les peuples autochtones, le recours à l'alcool comme moyen de faire face à un traumatisme fait aussi l'objet de travaux de recherche aux États-Unis. Selon Brave Heart (2003), la consommation d'alcool est vue comme une automédication permettant d'éviter les sentiments pénibles. La figure ci-dessous, qui donne les facteurs qui, pour les membres des Premières nations vivant dans des réserves en Saskatchewan, ont une grande influence sur le maintien de leur santé mentale, met en évidence l'influence majeure de l'abus d'alcool et de drogues sur la santé mentale (Centre des Premières nations, 2004).

Figure 4. Facteurs jugés très importants pour le maintien de la santé mentale

Abus d'alcool et de drogues, Manque de confiance aux autres, Reconnaissance des problèmes, Pénurie de personnel des Premières nations, Insuffisance des services, Manque de confiance en soi, Violence dans la famille, Violence verbale, Manque de modèles, Répugnance à discuter de ses émotions, Violence psychologique, Jeu compulsif, Violence physique, Violence contre les personnes âgées, Abus sexuels

Source : Enquête régionale sur la santé, 1997, résultats pour la Saskatchewan (Centre des Premières nations, 2004)

Les facteurs sociaux et culturels autochtones peuvent influencer sur la chronicité de la dépression. Par exemple, en Australie, où près des trois quarts (72 %) d'un échantillon d'Aborigènes ont déclaré que la dépression était une caractéristique innée qui ne pouvait pas être traitée, la dépression est chronique dans la majorité des cas (Vicary et Westerman, 2004). Cependant, aux États-Unis, les patients navajos qui trouvaient des causes et des interprétations culturelles à leur dépression ont réussi à parvenir à une rémission (c'est-à-dire sentiment d'équilibre et de bien-être et atténuation des symptômes de la dépression) grâce à des techniques de guérison individualisées et adaptées à la culture (Storck et coll., 2000). Par conséquent, le traitement « dépend des explications culturelles de la maladie » (Vicary et Westerman, 2004) et, en plus, le résultat du traitement dépend aussi de la culture. Ainsi, compte tenu des éléments de preuve sur les moyens non médicaux permettant de surmonter une dépression, les taux de dépression calculés à partir des données sur l'utilisation des services par les Autochtones sont probablement inférieurs aux taux réels (Kirmayer, Brass et Tait, 2000). Selon les données de l'Enquête régionale sur la santé de 2002-2003, 71,7 % des personnes qui se sentent tristes ou déprimées ont déclaré que leur famille et leurs amis étaient leurs premiers soutiens. Seulement 9,1 % et 8,4 % indiquaient les psychiatres ou les psychologues comme soutiens (Comité, 2005). Il faut faire

davantage de recherche sur la question pour déterminer comment mieux adapter les méthodes de dépistage (Jackson-Triche et coll., 2000).

7.2.3 Trouble de stress post-traumatique

Le trouble de stress post-traumatique est un trouble psychologique découlant d'un événement traumatisant pour l'individu (Chansonneuve, 2007; Corrado et Cohen, 2003; Mitchell et Maracle, 2005). Pour qu'il y ait diagnostic de trouble de stress post-traumatique, il faut que les symptômes suivants soient présents : l'événement traumatisant est revécu (flashbacks ou cauchemars), les stimuli associés à l'événement traumatisant sont évités, des fonctions physiologiques sont accentuées (comme une respiration rapide et un rythme cardiaque accéléré). Les effets sur le cerveau, les émotions, le corps et l'esprit incluent : anxiété; pensées et souvenirs obsédants; troubles du sommeil; accès de colère; réflexe de sursaut exagéré; hypersensibilité. Il n'est pas rare que le trouble de stress post-traumatique existe parallèlement à d'autres problèmes de santé mentale et physique comme la dépression, l'abus d'intoxicants, une maladie cardiaque, des problèmes d'estomac (Corrado et Cohen, 2003; Mitchell et Maracle, 2005).

Les données sur les taux de prévalence du trouble de stress post-traumatique parmi les populations autochtones du Canada et même d'ailleurs dans le monde, sont limitées. La majorité des travaux de recherche sur le trouble de stress post-traumatique dans les populations autochtones portent sur des échantillons d'Indiens américains adultes de tribus du Sud-Ouest et des plaines du Nord. Les anciens combattants provenant de ces tribus étaient plus susceptibles d'avoir un diagnostic de trouble de stress post-traumatique permanent que les anciens combattants caucasiens (Beals et coll., 2002). La prévalence du trouble de stress post-traumatique permanent chez les adultes de la tribu du Sud-Ouest était de 21,9 % et était plus élevée chez les femmes (25,4 %) que chez les hommes (17,9 %) (Robin, Chester, Rasmussen, Jaranson et Goldman, 1997). Dans la tribu des plaines du Nord, 15 % de l'échantillon répondait aux critères définissant le trouble de stress post-traumatique permanent et les personnes affectées étaient plus susceptibles que les autres de souffrir également de trouble dépressif majeur permanent et d'abuser de l'alcool (Sawchuk et coll., 2005). Les taux élevés de prévalence du trouble de stress post-traumatique constaté chez les adultes de ces tribus étaient attribuables à de hauts taux d'exposition à des événements traumatisants et pas à une plus grande vulnérabilité des Indiens d'Amérique à ce trouble (Robin et coll., 1997; Sawchuk et coll., 2005). Une équipe de recherche a constaté que, parmi un échantillon d'adolescents indiens d'Amérique suivant un traitement pour abus d'intoxicants, le pourcentage de ceux qui répondaient aux critères définissant le trouble de stress post-traumatique (10,3 %) était modeste comparativement à la proportion de ceux qui avaient connu des expériences traumatisantes (98 %) (Deters, Novins, Fickenscher et Beals, 2006). Les auteurs suggéraient que de futurs travaux de recherche portent notamment sur la résilience des jeunes Autochtones face à des traumatismes répétitifs.

Une minorité de survivants du système de pensionnats pour Autochtones présentent des symptômes semblables aux symptômes du trouble de stress post-traumatique tandis que beaucoup d'autres sont aux prises avec les symptômes qui s'y associent couramment, soit la difficulté d'établir des rapports avec les autres, des aptitudes parentales déficientes, des connaissances très lacunaires de la culture autochtone, peu d'intérêt pour les activités culturelles et une faible participation à ces activités, l'abus d'alcool ou de drogue associé à des accès de violence (Brasfield, 2001; Corrado et Cohen, 2003; Dion Stout et Kipling, 2003). L'expression

« syndrome du pensionnat » est parfois utilisée pour décrire ce groupe de symptômes, mais l'expression reste controversée parce qu'aucun critère de diagnostic précis n'a encore été officiellement établi (Brasfield, 2001). En outre, Chrisjohn et Young (1995) soutiennent qu'il est peu probable que l'on dégage un ensemble cohérent de symptômes associés aux pensionnats en raison du large éventail d'expériences et de comportements des survivants des pensionnats. Les travaux de recherche sur le trouble de stress post-traumatique parmi les groupes autochtones devraient être abordés avec précautions puisque les symptômes sont susceptibles de varier énormément d'une personne à l'autre de même qu'entre les populations autochtones et non autochtones en raison des situations et expériences uniques de chacun et des différentes façons de faire face aux problèmes.

7.2.4 Dépendances

Comme d'autres troubles mentaux, la dépendance n'a pas de définition établie ni de critères diagnostiques bien définis. Elle est parfois désignée à tort ou à raison par d'autres termes, comme accoutumance, toxicomanie ou compulsion. Pour les besoins de la présente étude, la dépendance est « un état résultant d'un comportement qui peut servir à la fois à engendrer du plaisir et à soulager d'un malaise et qui présente les caractéristiques suivantes : 1) incapacité récurrente de maîtriser le comportement (impuissance); 2) maintien du comportement malgré d'importantes répercussions négatives (ingérabilité) » (Goodman, 1990). La dépendance n'est pas synonyme d'accoutumance (gratification des besoins) ou de compulsion (évitement d'un malaise interne), mais implique à la fois l'accoutumance et la compulsion (Goodman, 1990). Les comportements dépendants peuvent aussi s'appliquer au jeu, à l'alimentation, au travail et aux substances psychoactives.

Bien que la dépendance aux substances psychoactives suppose l'abus d'intoxicants, l'abus d'intoxicants n'est pas toujours une dépendance (NNAPF, 2000). Il est souvent peu fréquent ou expérimental, ce qui n'est toutefois pas le cas pour toutes les populations. Des études indiquent que les caractéristiques de l'abus d'intoxicants diffèrent selon qu'il est question de populations autochtones ou non autochtones (Beauchamp et coll., 2004; Centre des Premières nations, 2005; Fournier et Crey, 1997; Santé Canada, 2003; Saggars et Gray, 1998; Thommasen, Hanlon, Thommasen et Zhang, 2006). La plupart des études sur l'utilisation d'intoxicants chez les Autochtones ont porté principalement sur le tabac et l'alcool. On peut dire que c'est le tabagisme qui a le plus d'effets à long terme sur la santé des Autochtones; pourtant, pour beaucoup de communautés autochtones, les effets immédiats de la consommation excessive d'alcool sur la santé et sur la vie sociale sont une préoccupation dominante (Saggars et Gray, 1998). Comme nous examinons l'usage du tabac (et son abus possible) plus loin dans la présente étude – en tant qu'important facteur de risque pour beaucoup d'autres maladies chroniques pendant le parcours de vie – il sera plutôt question ci-après de la dépendance à l'alcool.

Dépendance à l'alcool

Le modèle d'alcoolisme qui définit la dépendance à l'alcool comme une maladie chronique a de nombreux adeptes, mais d'autres le jugent limité. C'est celui qu'ont adopté par exemple les Alcooliques Anonymes, association qui a une large influence sur la conception et le traitement de la dépendance à l'alcool (Suissa, 2003). Beaucoup de gens trouvent du réconfort et un réseau social au sein des groupes ayant adhéré à ce modèle et réussissent à devenir sobres et à le rester. Suissa (2003) a fait valoir qu'il a aussi la faveur de certains groupes, dont les Irlandais et les

Autochtones, car il correspond à leur compréhension culturelle de l'alcool et de la dépendance. Toutefois, le fait que le modèle soit axé sur le principe du « tout ou rien », en l'occurrence sur la conviction qu'« une personne est – ou n'est pas – un alcoolique sa vie durant » (Suissa, 2003), limite son applicabilité et les modes de traitement. Ainsi, le principe du « tout ou rien » exige l'abstinence complète. Malheureusement, il ne tient pas compte des avantages que l'on pourrait tirer de brèves stratégies d'intervention et de réduction des méfaits. De plus, il ne peut s'appliquer à toutes les dépendances : les outre-mangeurs ne peuvent s'abstenir de manger, tout comme les bourreaux de travail ne peuvent arrêter de travailler (Goodman, 1990). Par conséquent, il faut parfois faire plus que s'abstenir pour vivre avec une dépendance ou pour la surmonter. Il pourrait être nécessaire d'apprendre aux personnes dépendantes les techniques qui favorisent une saine modération (Goodman, 1990).

Il reste que l'abstinence a aidé beaucoup d'Autochtones alcooliques à mener une vie saine et équilibrée. Une bonne partie des études sur la consommation d'alcool chez les Autochtones ont révélé que l'abstinence et une consommation moins fréquente sont plus courantes chez les Autochtones que les non-Autochtones (Centre des Premières nations, 2005; Fournier et Crey, 1997; Saggars et Gray, 1998; Thommasen et coll., 2006). Une grande proportion des abstinentes autochtones sont d'anciens buveurs (Saggars et Gray, 1998). Wardman et Quantz (2005) ont constaté, d'après un échantillon d'Autochtones de l'Ouest canadien, que la plupart des anciens buveurs ont dit avoir connu le fond de l'abîme avant de devenir abstinentes. Souvent, la consommation excessive occasionnelle servait à endormir la douleur causée par des violences physiques et sexuelles, une faible estime de soi, la perte de culture et d'identité et des antécédents familiaux d'abus d'intoxicants (Wardman et Quantz, 2005). De nombreuses personnes sobres ont trouvé la force de continuer grâce à une spiritualité renouvelée et à leur adhésion aux traditions culturelles. Dans une autre étude, les faits rapportés par des hommes navajos qui avaient déjà bu, mais étaient devenus abstinentes, donnaient à penser qu'il était courant chez eux de parvenir à une étape de la vie où la santé, la religion, la famille et la richesse prenaient le pas sur la consommation d'alcool (Quintero, 2000). Ces hommes associaient l'alcool à la perte des traditions et à un mode de vie déséquilibré. Souvent, ils ne ressentaient pas le besoin d'un traitement en bonne et due forme, car le désir de reprendre un mode de vie traditionnel était un motif d'abstinence suffisant.

Bien que le taux d'abstinence soit plus élevé et l'usage d'alcool moins fréquent, la consommation excessive occasionnelle est plus fréquente chez les Autochtones que les non-Autochtones qui consomment de l'alcool. Autrement dit, « ceux qui boivent ont tendance à boire beaucoup » (Canada, 2006). C'est probablement ce mode de consommation qui contribue aux problèmes d'alcool des communautés autochtones. En témoigne le fait que l'alcool était un facteur dans 6,4 % des blessures subies par des jeunes des Premières nations et dans plus du quart (27,1 %) des voies de fait commises contre eux (Centre des Premières nations, 2005). Rothe (2005) a signalé que, dans neuf communautés des Premières nations, les répondants considéraient l'abus d'alcool et la conduite sous l'influence de l'alcool comme des « comportements normaux, approuvés par la communauté » (Rothe, 2005). Chez les Indiens inscrits, près du quart (23,5 %) des décès sont liés à l'alcool et 6,2 % sont dus à la drogue (Officer, 2002). Des taux élevés de morbidité et de mortalité liées à l'alcool ont aussi été signalés en Australie (Saggars et Gray, 1998). Les Autochtones ont invoqué diverses raisons pour expliquer leur consommation d'alcool, notamment l'ennui de vivre dans une localité qui offre peu d'activités récréatives et d'emplois ainsi que le besoin de s'automédiquer pour

anesthésier la douleur causée par la pauvreté, le racisme et la violence. Par conséquent, la structure économique et sociale de la communauté est plus susceptible que les valeurs personnelles ou culturelles d'expliquer la prévalence élevée de l'abus d'alcool dans les communautés autochtones (Rothe, 2005).

7.3 Fardeau des maladies mentales graves pour la santé des communautés

La santé de la communauté est soumise à l'influence de l'environnement physique et du milieu social (Smye et Mussell, 2001) passés et présents (Centre des Premières nations, 2005). Le dysfonctionnement de la vie familiale et communautaire a de vastes répercussions sur la santé mentale (Mussell, Cardiff et White, 2004), et la santé mentale d'une personne peut avoir des effets sur sa famille et sa communauté. À l'inverse, l'amélioration des rapports familiaux et l'encouragement à la guérison de la communauté peuvent contribuer à la santé et au mieux-être (Canada, 2006; Warry, 1998). Dans cette optique, la section qui suit mettra en lumière l'effet que peuvent avoir les maladies mentales graves sur les communautés et le fardeau des maladies au sein des communautés.

Lorsqu'une population – autochtone ou non – est marginalisée et opprimée culturellement, sa santé mentale en souffre aux niveaux individuel, familial et communautaire (Canada, 2006). Les problèmes de santé mentale revêtent souvent la forme de fardeaux sociaux comme la violence familiale, l'abus d'intoxicants et le suicide (Canada, 2006; Warry, 1998). Même si les communautés autochtones réagissent différemment au traumatisme de la marginalisation et de l'oppression, beaucoup d'entre elles sont confrontées aux problèmes de la violence familiale, de l'abus d'intoxicants, de l'incarcération et du suicide (Canada, 2006; Frank, 1992; Kirmayer, Simpson et Cargo, 2003; Warry, 1998). Les problèmes sociaux et de santé mentale qui frappent certaines communautés sont souvent interreliés et trahissent l'existence de problèmes familiaux et communautaires plus vastes (Bohn, 2003; Frank, 1992). L'insuffisance des logements et des infrastructures et le manque d'installations récréatives sont quelques exemples de facteurs qui concourent à la perpétuation du traumatisme collectif et des stratégies d'adaptation destructrices qui font subsister les problèmes de santé mentale dans les communautés (Canada, 2006; Dion Stout et Kipling, 2003). La transmission des fardeaux sociaux d'une génération à l'autre dans une communauté fait que les problèmes de santé mentale peuvent devenir non seulement graves et persistants pendant toute la vie d'une personne, mais aussi chroniques à travers les générations. Sachant cela, on ne devrait pas se surprendre de voir que les méthodes de guérison axées uniquement sur l'individu ont une efficacité limitée au sein des populations autochtones (DeGagné, 2007; Mussell et coll., 2004). Les stratégies de guérison doivent tenir compte du fardeau des comportements individuels pour la vie familiale et communautaire (Warry, 1998). Par conséquent, même si la guérison individuelle est importante pour la guérison de la communauté dans son ensemble, les stratégies qui sont le plus efficaces pour assurer le mieux-être de la communauté encourageront à la fois la guérison individuelle et la guérison collective (Centre des Premières nations, 2005; Warry, 1998).

8. Répercussions des maladies chroniques sur la santé mentale

Les expériences vécues par les gens atteints de maladies chroniques constituent un aspect important de la littérature sur la recherche sur les maladies chroniques. Un sous-ensemble important de ces expériences, ce sont les répercussions que le fait d'avoir une maladie chronique a sur la santé mentale. Par conséquent, nous aborderons ici le lien entre maladie chronique et

santé mentale en répondant à trois questions clés : 1) comment les maladies chroniques et la santé mentale sont-elles liées? 2) pourquoi les maladies chroniques et la santé mentale sont-elles liées? 3) dans quelle mesure les maladies chroniques et la santé mentale sont-elles liées?

8.1 Définition des paramètres de l'association entre maladie chronique et santé mentale

L'association entre maladie chronique et santé mentale est souvent abordée sous l'angle de l'interconnexion entre maladie chronique et dépression. Comme on le voit dans la section sur la maladie mentale grave, beaucoup remettent en doute le fait que la dépression soit vraiment une maladie chronique. « Dépression majeure » est souvent l'expression utilisée pour désigner la dépression chronique puisqu'il a été relevé que la dépression grave a des effets à long terme sur le patient, sur sa propension à chercher de l'aide, sur l'environnement social et sur sa réponse au traitement (Van Weel-Baumgarten, 2005). Il a été constaté que les symptômes d'une dépression qui n'est pas une dépression majeure ont des effets importants sur le fonctionnement quotidien et le recours au système de santé (Sullivan et coll., 1999) et annoncent souvent une dépression plus grave (Hammen, 1997). La prévalence des symptômes infraliminaires de la dépression est au moins égale à celle de la dépression majeure et peut même être de deux à trois fois plus élevée (Sullivan et coll., 1999). Ainsi, il est important d'examiner les interactions entre la maladie chronique et tous les types de dépression. Après la dépression, nous aborderons un autre trouble psychologique, soit le trouble de l'adaptation, qui est lié à l'apparition de la maladie chronique.

8.1.1 Dépression

L'interconnexion entre maladie chronique et dépression est complexe. Non seulement des études ont révélé que les maladies chroniques causent la dépression, mais on a constaté que la dépression fait partie des facteurs de risque indépendants liés au développement de certains types de maladie chronique. On associe également la dépression à des résultats inférieurs, à un taux de mortalité accru et à des coûts de soins de santé plus élevés. La présence de la dépression influe sur les comportements de santé : les gens sont moins susceptibles de prendre des décisions qui favorisent un mode de vie sain ou de respecter leur traitement médical. On a découvert que la dépression avait une incidence sur la perception des maladies; ainsi, les gens dépressifs se sentent plus malades que ce que des examens médicaux objectifs prédiraient. Les dépressifs ayant également des seuils de douleur plus faibles que les autres personnes, leurs symptômes sont plus douloureux.

La dépression peut avoir des effets physiologiques directs sur des maladies; par exemple, chez les diabétiques, on a associé des épisodes de dépression à une glycémie élevée. Chez les personnes souffrant de coronaropathie, on a étudié le lien entre la dépression et les changements concernant les taux lipidiques, les réactions physiologiques et la fonction plaquettaire (Davidson et coll., 2006; Glassman et Shapiro, 1998; Hippiusley-Cox, Fielding et Pringle, 1998; Lesperance, Frasure-Smith et Talajic, 1996; Pratt et coll., 1996). De surcroît, certains médicaments utilisés pour traiter les maladies chroniques causent la dépression (Katon et Sullivan, 1990) et certains médicaments utilisés dans le traitement de la dépression ont des répercussions sur les maladies chroniques. C'est le cas d'anciennes catégories d'antidépresseurs, qui ont des effets coronariens (Davidson et coll., 2006; Pratt et coll., 1996). La dépression peut être un symptôme d'une maladie chronique, notamment dans les cas d'accident vasculaire cérébral (Fava et Kendler,

2000), et on peut confondre les symptômes de la dépression et les signes et symptômes d'une cardiopathie.

8.1.2 Trouble de l'adaptation

Le trouble de l'adaptation est un autre trouble psychologique associé au début d'une maladie chronique. La plupart des gens souffrant d'une maladie chronique ne présentent pas de dépression clinique, mais souffrent plutôt d'un « trouble de l'adaptation ». Il s'agit d'un trouble non psychotique lié au stress et limité dans le temps qui apparaît dans les trois mois suivant l'arrivée du facteur stressant et qui disparaît dans une période de six mois (Casey, 2001; O'Keeffe et Ranjith, 2007; Rush, Polatin et Gatchel, 2000). C'est un trouble grave qui touche jusqu'au quart des patients, tous âges confondus, ne présentant aucun trouble mental antérieur (Casey, 2001; Strain et coll., 1998). Le trouble de l'adaptation complique l'évolution de l'état médical (Casey, 2001).

On considère le trouble de l'adaptation comme une réaction compréhensible, mais mésadaptée, à un événement stressant, réaction qui se dissipe spontanément quand le facteur de stress disparaît ou quand on atteint un nouveau niveau d'adaptation (O'Keeffe et Ranjith, 2007). On arrive à un diagnostic du trouble de l'adaptation quand le patient ne satisfait pas aux critères diagnostiques de troubles tels l'épisode dépressif ou la dépression majeure ou mineure (Casey, 2001; Casey et coll., 2006; Takei et Sugihara, 2006). Certains cliniciens préfèrent poser un diagnostic de trouble de l'adaptation plutôt que d'autres troubles dépressifs, car ils ne veulent pas « médicaliser » ce qu'ils estiment être une réaction naturelle à la maladie (Casey, 2001; O'Keeffe et Ranjith, 2007). Cela est en dépit du fait qu'on a accusé le terme « trouble de l'adaptation » de placer une réaction humaine dans le domaine de la biomédecine.

Le trouble de l'adaptation englobe des symptômes et des comportements mentaux graves (Casey, 2001; Strain et coll., 1998) qui sont indifférenciables d'autres troubles dépressifs sur le plan de la gravité des symptômes (Casey et coll., 2006). Malgré le fait que le trouble de l'adaptation soit associé à des taux de morbidité et de mortalité qui laissent autant à désirer que ceux d'autres troubles dépressifs (Jones, Yates, Williams, Zhou et Hardman, 1999; O'Keeffe et Ranjith, 2007) et le fait que jusqu'à 15 % des gens souffrent subséquemment de dépression majeure (Takei et Sugihara, 2006), de nombreux cliniciens tardent à offrir un traitement (Strain et coll., 1998). Selon Casey (2001), cette absence de traitement s'explique par le fait que la majorité des gens aux prises avec un trouble de l'adaptation se rétablissent rapidement. Il est donc complètement improbable que des interventions précises s'imposent (Casey, 2001). Par exemple, chez les personnes qui font des crises cardiaques, le risque de mourir est associé à une dépression récurrente plutôt qu'à un seul épisode de dépression majeure se produisant après la crise cardiaque (Lesperance et coll., 1996). La dépression est souvent plus grave immédiatement après un infarctus du myocarde et peut constituer une réaction passagère à l'infarctus lui-même (Davidson et coll., 2006).

Cependant, immédiatement après l'apparition d'une maladie, il est impossible de distinguer les personnes chez qui le trouble de l'adaptation va disparaître avec le temps de celles qui se mettront à souffrir d'une dépression majeure. Les données disponibles indiquent qu'un traitement peut se révéler aussi bénéfique pour les patients atteints du trouble de l'adaptation que pour les patients souffrant d'autres troubles dépressifs (Jones et coll., 1999). Pour prendre des décisions quant au traitement, il convient de tenir compte de la haute prévalence du trouble de

l'adaptation, des ressources et du temps requis pour traiter ce trouble (Strain et coll., 1998) et des bénéfices possibles pour le patient. Peut-être en raison de sa courte durée inhérente et des taux de rétablissement relativement élevés, on a effectué très peu de recherche sur ce trouble (Casey, 2001; Casey et coll., 2006; O'Keeffe et Ranjith, 2007).

Il existe une différence fondamentale entre ce trouble, qui est limité dans le temps et qui est lié à une maladie, et la dépression majeure. Étant donné que le trouble de l'adaptation a fait l'objet de si peu de travaux de recherche et qu'on ne l'a pas inclus pas dans les études récentes, il est possible que, dans bon nombre d'études de recherche sur des maladies, la prévalence des troubles dépressifs soit présentée de manière inexacte. D'après Casey et ses collaborateurs, le nombre d'épisodes de dépression légère et d'épisodes de dépression combinée inclut le nombre d'épisodes de trouble de l'adaptation (Casey et coll., 2006).

Certains auteurs soutiennent que le terme exact employé au moment du diagnostic n'a aucune importance quand il s'agit de traiter le patient (O'Keeffe et Ranjith, 2007). Au lieu de se demander si un patient souffre du trouble de l'adaptation ou d'une dépression majeure ou mineure, O'Keeffe affirme qu'il vaudrait mieux se demander quels sont les problèmes actuels du patient et comment les gérer (O'Keeffe et Ranjith, 2007). De cette manière, les cliniciens pourraient utiliser des antidépresseurs pour l'anhédonie, des méthodes existentielles ou spirituelles pour le découragement, des méthodes psychoéducatives ou cognitives pour l'adaptation mésadaptée et une stratégie d'activation comportementale pour la piètre motivation et l'impuissance acquise, lorsque cela est indiqué, chez le même patient.

8.2 Analyse de l'association entre maladie chronique et santé mentale

La difficulté que posent la définition et la description de l'association entre maladie chronique et trouble mental, c'est qu'il existe de nombreux mécanismes d'interaction possibles entre les deux. Le tableau ci-dessous, qui est une version simplifiée du tableau présenté dans Prince, Patel et coll. (2007), en fait l'illustration.

Tableau 4. Mécanismes d'interaction possibles entre les troubles mentaux et les autres troubles de santé

Les troubles mentaux ont une incidence sur les taux liés aux autres troubles

- Les troubles mentaux sont associés à des facteurs de risque des maladies chroniques, notamment l'usage du tabac, le manque d'activité, une mauvaise alimentation, l'obésité et l'hypertension. Toutefois, on n'a pas encore démontré que ces facteurs liés au mode de vie étaient associés à la morbidité et la mortalité.
- La dépression a divers effets biologiques sur : le métabolisme de la sérotonine (modification de la fonction cardiaque, agrégation plaquettaire et vasoconstriction); le métabolisme du cortisol (hausse du taux de cortisol menant à l'inflammation, coagulation excessive, syndrome métabolique); le processus inflammatoire (marqueurs inflammatoires élevés, ce qui est un signe avant-coureur du développement d'une maladie cardiovasculaire); l'immunité à médiation cellulaire (dégradation des fonctions médiées par les lymphocytes T, réduction du nombre de cellules tueuses naturelles et cytotoxicité, en ce qui concerne le cancer, progression du VIH et autres maladies infectieuses).
- Les troubles mentaux et les autres troubles de santé pourraient avoir des facteurs de risque génétiques ou environnementaux communs.

Certains troubles de santé influent sur le risque de troubles mentaux

- De nombreuses maladies chroniques créent un fardeau psychologique, lequel découle de facteurs tels que le traumatisme aigu lié au diagnostic, la difficulté de vivre avec la maladie, la menace à long terme de décliner et de voir son espérance de vie réduite, les modifications nécessaires au mode de vie, les régimes thérapeutiques compliqués, les symptômes aversifs comme la douleur, et les stigmates, qui peuvent conduire à un sentiment de culpabilité, à la perte du soutien social ou à la rupture des relations clés.
- L'incapacité qui est associée aux maladies chroniques peut entraîner le risque de souffrir de dépression et d'autres troubles mentaux communs.

Certains troubles mentaux comorbides influent sur le traitement et les résultats d'autres troubles de santé

- Les troubles mentaux peuvent retarder la recherche d'aide et réduire la probabilité de la détection ou du diagnostic, ou les deux.
- L'étendue et la qualité des soins médicaux généraux que reçoivent les gens atteints de troubles mentaux peuvent être médiocres. Cette iniquité est particulièrement forte dans le cas de personnes souffrant de psychoses, de démence et de troubles liés à l'utilisation d'intoxicants.
- Les troubles mentaux, les troubles cognitifs et les troubles liés à l'utilisation d'intoxicants et d'alcool ont un effet défavorable sur l'observance du traitement médicamenteux, sur l'application des recommandations de modification des comportements et sur la réalisation d'activités destinées à prévenir la maladie ou à favoriser la santé.

(Prince et coll., 2007)

La liste d'interactions possibles est longue. Les interactions récurrentes entre maladie physique chronique et santé mentale sont communes, chacune renforçant et exacerbant l'autre (Dowrick, 2006). Néanmoins, la prévalence de la dépression varie selon la maladie chronique (Penninx et

coll., 1996). Les constatations de cet imposant corpus de recherche sont quelque peu contradictoires.

8.2.1 Variabilité de la prévalence des troubles mentaux selon la maladie chronique

D'après certaines études, la prévalence de la détresse psychologique varie peu selon la maladie chronique (Cassileth et coll., 1984). D'autres études ont indiqué que certaines maladies chroniques étaient associées à des niveaux élevés de perturbation psychologique, notamment l'arthrite et les rhumatismes (Penninx et coll., 1996; Wells, Golding et Burnam, 1988), le cancer (Wells et coll., 1988), les maladies pulmonaires, les troubles neurologiques (Ormel et coll., 1997; Wells et coll., 1988), les maladies du cœur (Ormel et coll., 1997; Wells et coll., 1988), les douleurs au bas du dos (Carroll, Cassidy et Côté, 2000; Rush et coll., 2000), les accidents vasculaires cérébraux (Penninx et coll., 1996), la déficience auditive, la déficience visuelle (Ormel et coll., 1997), les maux de tête, les problèmes gastrointestinaux (Carroll et coll., 2000) et les handicaps physiques. Enfin, d'autres études ont révélé que certains troubles chroniques, par comparaison à d'autres troubles, ne sont pas associés à un risque accru de perturbation psychologique, notamment l'hypertension (Patten, 1999; Wells et coll., 1988), l'arthrite (Patten, 1999), les maladies du cœur (Patten, 1999; Penninx et coll., 1996) et le diabète (Patten, 1999; Penninx et coll., 1996; Wells et coll., 1988). Le fait que des études associent bon nombre de ces troubles à une perturbation psychologique accrue et que d'autres études n'associent pas ces mêmes troubles à une perturbation psychologique accrue donne à penser qu'il y a encore beaucoup à apprendre sur la relation entre dépression et maladie chronique.

On a invoqué diverses raisons pour expliquer la variation des effets psychologiques selon la maladie chronique. Certains affirment que ce n'est pas le type de maladie qui influe sur les taux de dépression, mais bien d'autres facteurs sociaux et psychologiques (Arpin, Fitch, Browne et Corey, 1990). D'autres indiquent que le niveau de dépression est directement lié à la gravité de l'incapacité découlant de la maladie chronique (Ormel et coll., 1997). D'autres auteurs avancent que le degré de gérabilité de la maladie est un élément prépondérant. Par exemple, contrairement au cancer et à l'arthrite, le diabète et les maladies cardiaques se gèrent relativement bien au moyen d'efforts individuels ou médicaux; par ailleurs, en modifiant leur comportement, en changeant leur régime alimentaire, en prenant des médicaments et faisant de l'exercice physique, les gens peuvent améliorer leur état de santé. (Penninx et coll., 1996). Certains affirment que la signification que l'on donne à la maladie est le facteur le plus important de l'adaptation (Arpin et coll., 1990). Selon Arpin, Fitch et leurs collaborateurs, 57 % de la variation des résultats liés à l'adaptation est attribuable à la signification donnée à la maladie, suivie du fonctionnement familial et des variables de l'incapacité (Arpin et coll., 1990).

8.2.2 Écart démographique

Dans la population générale, la dépression majeure est plus répandue chez les jeunes et chez les femmes (Hammen, 1997). Dans la population autochtone également, la dépression touche plus souvent les femmes (Thommasen et coll., 2005; Wardman et Khan, 2004). Compte tenu du fait que la population autochtone est jeune par comparaison avec la population générale et du fait que les maladies chroniques apparaissent à un âge relativement bas chez les Autochtones, la relation entre l'âge, la dépression et les maladies chroniques est importante.

D'après des études épidémiologiques et cliniques cumulatives dont fait état la littérature générale, les enfants qui ont une maladie ou une incapacité chronique courent un risque accru de souffrir de problèmes mentaux (Cadman, Boyle, Szatmari et Offord, 1987; Chernoff, Ireys, DeVet et Kim, 2002; Haggerty, Roghmann et Pless, 1975; Lavigne et Faier-Routman, 1992; Stein, Westbrook et Silver, 1998; Suris, Michaud et Viner, 2004; Wolman, Resnick, Harris et Blum, 1994; Yeo et Sawyer, 2005). De plus, on a noté chez les adolescents atteints d'une maladie chronique des troubles émotionnels et des tendances suicidaires plus forts que chez les autres adolescents et ils obtiennent des résultats psychologiques inférieurs à ceux de leurs pairs en ce qui a trait au bien-être émotionnel, aux inquiétudes et aux préoccupations et à l'image du corps (Miauton, Narring et Michaud, 2003; Rosina, Crisp et Steinbeck, 2003; Suris et coll., 2004; Wolman et coll., 1994).

Les résultats d'une étude menée à l'échelle d'une population ont révélé que la prévalence estimée des diagnostics de trouble psychiatrique chez les enfants atteints d'une maladie chronique était de 10 %, soit près du double de la prévalence observée chez les enfants ne souffrant pas de maladie chronique (Hysing, Elgen, Gillberg, Lie et Lundervold, 2007). Ces résultats cadrent avec ceux d'études précédentes. L'étude de l'île de Wight est l'exemple classique; on a relevé des taux de troubles psychiatriques de 11,6 % chez les enfants atteints de troubles physiques chroniques non liés au cerveau, de 34,4 % chez les enfants atteints de troubles neuroépileptiques et de 7 % chez les enfants en santé (Rutter, Graham et Yule, 1970). Dans les années 1980, une étude menée à l'échelle d'une population en Ontario a donné les résultats suivants : chez les enfants souffrant à la fois d'une maladie chronique et d'une incapacité connexe, le risque de souffrir de troubles psychiatriques était plus de trois fois plus élevé que chez les enfants en santé et le risque d'avoir des problèmes d'adaptation sociale était considérable. Le risque était moins grand chez les enfants atteints d'une maladie chronique n'entraînant pas d'incapacité; le risque de souffrir de troubles psychiatriques était environ deux fois plus élevé que chez les enfants en santé. Toutefois, le risque d'avoir des problèmes d'adaptation sociale n'était pas tellement accru (Cadman et coll., 1987).

Au sein des Premières nations, les adolescents ayant une incapacité semblent plus enclins à la dépression, définie comme le fait de se sentir triste, d'avoir le cafard ou d'être déprimé plus de deux semaines d'affilée pendant l'année de référence (35,6 % par comparaison avec 26,5 % chez les jeunes ne souffrant pas d'incapacités). Les adolescents ayant une incapacité sont également plus susceptibles d'envisager le suicide à un moment donné de leur vie (32,4 % par comparaison avec 20,1 %) (Centre des Premières nations, 2005).

8.2.3 Maladies chroniques et santé mentale – relation dans des conditions chroniques particulières

Afin d'enrichir la discussion de la variance générale dans la relation entre les maladies chroniques et la santé mentale, la littérature documente la relation particulière entre trois des maladies chroniques discutées plus haut dans cette section : 1) le diabète, 2) les maladies cardiovasculaires et 3) les maladies squeletto-musculaires. L'information sera tirée de la littérature générale, avec une référence à la recherche autochtone lorsqu'elle est disponible.

Diabète

Dans la population autochtone canadienne, on peut soutenir que la recherche sur le diabète est la plus prolifique des recherches sur les maladies chroniques. Malgré ce fait, peu de recherches ont porté sur l'aspect mental de cette maladie. Peut-être est-ce parce que cette maladie chronique est également considérée comme l'une des plus complexes d'un point de vue psychosocial (Gonder-Frederisk, Cox et Clarke, 2002). En effet, le diagnostic, le traitement et la prévention du diabète comportent de multiples facettes et la gestion de la maladie est délicate :

Il n'y a aucune guérison, le diagnostic peut survenir à n'importe quel stade de la vie et, après le diagnostic, un traitement quotidien est nécessaire pour le reste de la vie, qui peut ou non prévenir le développement de complications à long terme graves, comme les maladies cardiovasculaires et du rein. Le régime de gestion peut être très complexe et dépend presque uniquement des efforts quotidiens intensifs du patient et de sa famille (Gonder-Frederisk et coll., 2002).

Ainsi, l'interrelation entre le diabète et la santé mentale doit être examinée avec soin. La recherche à ce sujet a commencé au cours des trente dernières années; les résultats de ce travail seront examinés pour décrire les relations évidemment complexes entre le diabète et la dépression.

On croit que la relation entre le diabète et la dépression peut aller dans les deux sens : la dépression peut jouer un rôle dans le développement du diabète et l'empirer (Sacco et coll., 2007) ou la dépression peut être le résultat du fait de vivre avec une maladie chronique et la diminution de la qualité de vie qui s'ensuit (Anderson, Freedland, Clouse et Lustman, 2001; Gonder-Frederisk et coll., 2002; Knol et coll., 2006; Peyrot et Rubin, 1997). Des études prospectives ont montré que les gens qui ont une dépression ont jusqu'à deux fois plus de risques d'avoir le diabète de type 2 indépendamment des autres facteurs de risque associés (Eaton, Pratt, Armenian, Ford et Gallo, 1996; Kawakami, Takatsuka, Shimizu et Ishibashi, 1999; Knol et coll., 2006). Les études rétrospectives ont également permis de constater une plus grande propension à la dépression chez les diabétiques que chez les non-diabétiques (Gonder-Frederisk et coll., 2002; Lustman, Griffith, Freedland, Kissel et Clouse, 1998; Nichols et Brown, 2000; Peyrot et Rubin, 1997). Les estimations exactes varient (Anderson, Lustman, Clouse, De Groot et Freedland, 2000; Bell et coll., 2005; de Groot et Lustman, 2001; Gavard, Lustman et Clouse, 1993; Goldney, Phillips, Fisher et Wilson, 2004; Nichols et Brown, 2000), mais, généralement, le taux de diabétiques souffrant d'une dépression est de deux à trois fois supérieur à celui de la population en général – atteignant jusqu'à un tiers des diabétiques de type 1 ou de type 2 (Anderson et coll., 2001; Anderson et coll., 2000; Egede, 2005; Gonder-Frederisk et coll., 2002).

La dépression chez les diabétiques est associée à des concentrations élevées de glucose dans le sang, à un faible contrôle de la glycémie, à un mauvais mode de vie, à une faible observance du traitement, à une piètre qualité de vie, à des coûts considérablement plus élevés pour les soins de santé, à un risque accru de complications et à une plus grande mortalité (Anderson et coll., 2001; Egede, 2005; Gavard et coll., 1993; Goldney et coll., 2004; Gonder-Frederisk et coll., 2002; Kawakami et coll., 1999; Keawe'aimoku Kaholokula, Haynes, Grandinetti et Chang, 2006; Lustman et coll., 2000; McGill et coll., 1992; Peyrot et Rubin, 1997; Sacco et coll., 2007; Winokur, Maislin, Phillips et Amsterdam, 1988). Il a été démontré que les patients diabétiques déprimés ont des concentrations de sucre élevées dans le sang durant un épisode de dépression et

mettent plus de temps à se rétablir que les sujets non déprimés (Winokur et coll., 1988). Souvent, la dépression peut être un meilleur indicateur des conséquences de la maladie que les variables physiologiques (Knol et coll., 2006; Rubin et Peyrot, 1999). Il a été démontré que l'anxiété chronique est associée à l'hémoglobine glycosylée HbA_{1c}, une mesure de contrôle du diabète (Okada et coll., 1995). La même étude a permis de constater que la diminution de l'anxiété pourrait être utile pour contrôler le métabolisme du glucose (Okada et coll., 1995).

Au Canada, on a trouvé une seule étude qui s'intéresse à la relation entre la qualité de vie, le diabète et la dépression chez les Autochtones. Cette étude a permis de constater que les Autochtones ont une qualité de vie inférieure à celle des non-autochtones et que le nombre moyen de jours de mauvaise santé mentale est supérieur chez les Autochtones que dans les populations non autochtones (Thommasen, Berkowitz, Thommasen et Michalos, 2005). Seulement quelques études menées aux États-Unis ont examiné la prévalence des symptômes de dépression chez les indigènes diabétiques (Bell et coll., 2005; Sahmoun, Markland et Helgersson, 2007; Singh et coll., 2004; Tann, Yabiku, Okamoto et Yanow, 2007). Ces études présentent des résultats contradictoires. Certaines études ont montré que la prévalence des symptômes de dépression était plusieurs fois plus élevée chez les Amérindiens diabétiques que dans les autres ethnies (Tann et coll., 2007) et que chez les autres Amérindiens non diabétiques (Sahmoun et coll., 2007; Singh et coll., 2004), et supérieure, mais pas tellement significativement, à celle des autres minorités ethniques (Bell et coll., 2005). D'autres études n'ont montré aucune association entre la race et la mesure de la dépression lorsque les autres facteurs démographiques et de maladie étaient contrôlés (Peyrot et Rubin, 1997). La pauvreté des études sur les minorités ethniques, et sur les Autochtones canadiens en particulier, signifie qu'on en sait peu sur la prévalence de la dépression dans la population diabétique autochtone, les variations régionales, les caractéristiques démographiques et médicales associées à des taux plus élevés de dépression, les conséquences médicales de la dépression, le recours aux soins de santé ou les traitements efficaces et appropriés sur le plan culturel (Bell et coll., 2005; Rock, 2003).

La littérature a documenté une relation entre la dépression et les complications liées au diabète (de Groot, Anderson, Freedland, Clouse et Lustman, 2001), bien que la direction de la relation ne soit pas claire. Les diabétiques qui sont déprimés sont à risque accru de complications liées au diabète et plus le nombre de complications liées au diabète est élevé ou plus les complications sont graves, plus le niveau de dépression est élevé (de Groot, Anderson, Freedland, Clouse et Lustman, 2000; de Groot et coll., 2001; Peyrot et Rubin, 1997). La dépression peut jouer un rôle dans certaines complications (p. ex. la macroangiopathie), mais pas dans d'autres (p. ex. la néphropathie) (de Groot et coll., 2001). Puisque la prévalence de certains types de complications est plus élevée chez les Autochtones (p. ex. les complications rénales) (Hanley et coll., 2005) et que le taux de complications liées au diabète est plus élevé chez les Autochtones au Canada que dans la population en général (Hanley et coll., 2005; Santé Canada, 2000; Meatherall et coll., 2005; Simpson et coll., 2003), il faudra mieux comprendre la relation entre la dépression et les complications les plus courantes chez les Autochtones, comme la néphropathie.

Maladies cardiovasculaires

Comme nous l'avons mentionné plus haut, les maladies cardiovasculaires constituent un groupe hétérogène de maladies du cœur et des vaisseaux sanguins, parmi lesquelles la maladie coronarienne et la cardiopathie ischémique sont les plus courantes. Bien qu'on ait constaté que

les maladies cardiovasculaires sont légèrement plus fréquentes dans la population des Premières nations, les taux chez les autres groupes autochtones sont limités. Lorsqu'on parle des maladies cardiovasculaires, il est important de noter leur interaction avec le diabète et les facteurs de risque de diabète (Bruce et coll., 2003; Simpson et coll., 2003). Cette relation est importante dans le contexte autochtone, car on a constaté que le diabète et les maladies cardiovasculaires présentent des taux de prévalence élevés. En outre, les diabétiques qui souffrent d'une dépression ont un risque accru de souffrir de maladies cardiovasculaires : on a constaté que la dépression est un facteur de risque indépendant pour le développement d'une maladie coronarienne chez les diabétiques (Anderson et coll., 2001). Egede (2005) a découvert que, chez les personnes ayant le diabète accompagné de dépression, le risque de décéder d'une cause ou d'une autre est beaucoup plus élevé, dépassant celui des personnes ayant uniquement le diabète ou une dépression, bien que le diabète demeure un indicateur de mortalité par maladie coronarienne plus important que la dépression (Egede, 2005). La recherche sur l'interrelation entre les maladies cardiovasculaires et la dépression sera examinée plus en détail ci-après.

Des études transversales et de cas-témoins ont montré que les taux de dépression sont supérieurs chez les patients souffrant d'une maladie coronarienne que dans la population en général (Pratt et coll., 1996). Jusqu'à 20 % des patients souffrant d'une maladie coronarienne satisfont aux critères d'une dépression majeure (Davidson et coll., 2006), ce qui correspond à trois fois la prévalence dans la communauté (Rozanski, Blumenthal et Kaplan, 1999). Entre 15 et 45 % des patients admis à l'hôpital à la suite d'un infarctus du myocarde sont déprimés et de 40 à 50 % présentent des niveaux d'anxiété de modérés à graves (Bennett et Carroll, 1997; Glassman et Shapiro, 1998; Hippiisley-Cox et coll., 1998).

La dépression a été considérée comme un facteur de risque indépendant équivalent aux autres facteurs pronostiques médicaux considérés comme des facteurs de risque du développement ou de l'aggravation de maladies cardiovasculaires (Broadley, Korszun, Jones et Frenneaux, 2002; Davidson et coll., 2006; Frasure-Smith et Lesperance, 2005; Glassman et Shapiro, 1998; Hippiisley-Cox et coll., 1998; Smith et Ruiz, 2002; Sullivan et coll., 1999). Plusieurs études soutiennent la notion de gradient entre l'ampleur de la dépression et de futurs événements cardiaques, laissant entendre que le risque de maladie coronarienne associée à la dépression existe selon un continuum, le risque relatif dépendant de l'ampleur des symptômes de dépression (Glassman et Shapiro, 1998; Rozanski et coll., 1999).

Chez les patients souffrant d'une maladie coronarienne préexistante, la dépression a généralement été associée à l'aggravation de la maladie (Carver, 2007; Glassman et Shapiro, 1998). Les estimations des effets de la dépression sur la maladie du cœur varient d'une étude à une autre, mais établissent que le risque de maladie cardiaque mortelle varie d'une fois et demie à sept fois (Broadley et coll., 2002; Davidson et coll., 2006; Frasure-Smith et Lesperance, 2000; Pratt et coll., 1996). La dépression est également associée à des résultats médicaux négatifs comme la faible observance du traitement et le recours accru aux soins médicaux (Gilmer et coll., 2005), une morbidité et une mortalité accrues, et une diminution de la qualité de vie (Davidson et coll., 2006; Hippiisley-Cox et coll., 1998; Lustman, Clouse, Griffith, Carney et Freedland, 1997), même à de faibles niveaux (Davidson et coll., 2006). Une étude a permis de constater un risque accru de mortalité cardiaque ou d'infarctus chez 72 % de ses participants qui présentaient seulement deux symptômes de dépression, un niveau de dépression insuffisant pour diagnostiquer une dépression majeure ou même une dépression mineure (Horsten, Mittleman,

Wamala, Schenck-Gustafsson et Orth-Gomér, 2000). Chez ceux qui ont souffert d'une crise cardiaque, les niveaux de dépression ou d'anxiété supérieurs sont associés à une mortalité et à une morbidité plus élevées, à un faible rétablissement émotionnel, au manque d'amélioration à court terme et à une période de latence plus longue avant de revenir aux niveaux d'activité normaux (Bennett et Carroll, 1997; Gorkin, Follick, Wilkin et Niaura, 1994; Pratt et coll., 1996; Smith et Ruiz, 2002).

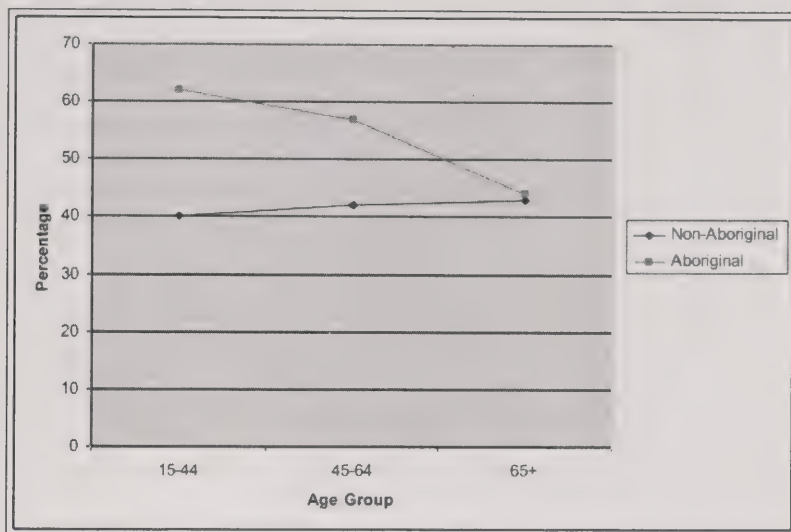
Une étude chez des aborigènes australiens a montré que le stress et l'inquiétude associés à un changement de situation sociale dans la communauté étaient souvent identifiés comme une cause perçue de maladie cardiaque et comme un facteur de complication dans la gestion de la maladie (Ong et Weeramanthri, 2002). La communauté considérait la maladie cardiaque comme un symbole des problèmes sociaux contemporains et d'une orientation incertaine de la communauté (Ong et Weeramanthri, 2002). Citant Humphrey et coll., 1998, Ong et Weeramanthri (2002) indiquent que le stress et l'inquiétude éprouvés par les indigènes n'étaient souvent pas reconnus par les non-indigènes, qui considèrent le stress comme étant associé uniquement à un mode de vie moderne et à la surcharge de travail. Comme Skinner et Silverman-Peach (1989) le décrivent, les fournisseurs de soins de santé non indigènes perçoivent souvent à tort le comportement stoïque des indigènes (en présence des non-indigènes) comme indiquant l'absence de stress (Skinner et Silverman-Peach, 1989).

Maladies squeletto-musculaires

Tel qu'indiqué dans la section sur le fardeau squeletto-musculaire, l'arthrite est l'une des maladies chroniques dont la prévalence est la plus élevée au Canada et une importante cause de morbidité, d'incapacité et de recours aux soins de santé (Lagacé, Perruccio, DesMeules et Badley, 2003). Une grande partie de la littérature porte sur la prévalence des affections squeletto-musculaires qui utilisent les termes arthrite ou rhumatisme pour décrire cet ensemble de douloureuses maladies des articulations allant de celles associées à l'usure du cartilage (ostéoarthrite) à celles associées à une inflammation découlant d'un trouble immunitaire (arthrite rhumatoïde). Ainsi, il est souvent trop difficile de distinguer les deux affections. Bien que la relation entre l'arthrite et l'ostéoarthrite et la santé mentale soit associée à une source d'information chaque fois qu'il est possible de le faire, des statistiques relatives à l'arthrite et au rhumatisme sont également utilisées.

Le taux d'arthrite et de rhumatisme est une fois et demie plus élevé chez les Premières nations et les Inuits que dans la population canadienne en général (Comité, 2004). Ainsi, chez les adultes autochtones, l'arthrite et le rhumatisme sont les affections chroniques les plus souvent déclarées (Statistique Canada, 2003) avec une prévalence standardisée pour l'âge de 27 % comparativement à 16 % dans la population non autochtone (Comité, 2005; Lagacé et coll., 2003). Puisque la prévalence de l'arthrite et du rhumatisme augmente avec l'âge (Lagacé et coll., 2003), l'impact de l'arthrite et du rhumatisme sur la population autochtone devrait augmenter à mesure que la population continue de vieillir (Burke, Zautra, Schultz, Reich et Davis, 2002).

Figure 5. Proportion des personnes arthritiques déclarant une mesure HUI indiquant une incapacité, par âge, autochtones vivant hors réserve et non autochtones, membres du ménage de 15 ans et plus, Canada, 2000



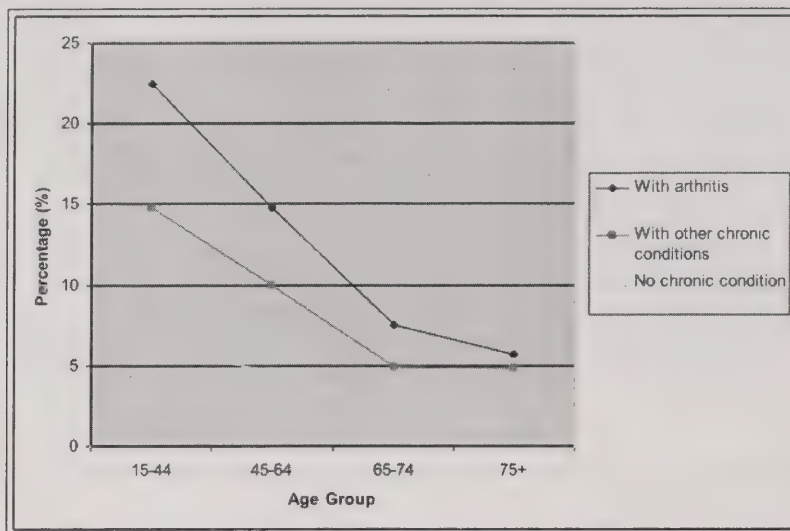
Source : (Lagacé et coll., 2003)

Les personnes arthritiques sont plus susceptibles que les personnes ayant d'autres maladies chroniques et non chroniques de souffrir de limitations des activités, d'une incapacité accrue et de douleurs allant de modérées à graves (Lagacé et coll., 2003; Verbrugge, Lepkowski et Konkol, 1991). Verbrugge, Lepowski et coll. (1991) ont constaté qu'en comparant des personnes arthritiques et non arthritiques ayant le même nombre d'affections, les arthritiques avaient plus de limitations physiques de toutes sortes (Verbrugge et coll., 1991). Ils ont également constaté que lorsque l'arthrite est accompagnée d'autres affections chroniques, les niveaux d'incapacité augmentent considérablement. Par exemple, pour la marche, Verbrugge, Lepowski et coll. (1991) ont constaté que le risque d'incapacité était multiplié par 100 chez les personnes arthritiques souffrant d'autres affections chroniques (rapport de cotes de 113,3) comparativement au rapport de cotes de 46,5 pour les personnes souffrant d'autres affections chroniques (sans l'arthrite) (Verbrugge et coll., 1991). On a également constaté que le taux d'incapacité est plus élevé chez les Autochtones arthritiques que chez les non-autochtones arthritiques, comme l'illustre la figure 2 ou 5? (Lagacé et coll., 2003).

Comme l'incapacité et la douleur sont associées à un risque accru de dépression, les personnes souffrant d'arthrite ou de rhumatisme sont particulièrement à risque de dépression (Barlow, Cullen et Rowe, 1999). Les personnes souffrant d'arthrite ou de rhumatisme sont plus sujettes à la dépression que la population en général (Batlow, Cullen et Rowe, 1999; Dickens, McGowan, Clark-Carter et Creed, 2002; Hawley et Wolfe, 1993; Lagacé et coll., 2003; Lin et coll., 2003; Nagyoca, Stewart, Macejova, van Dijk et van de Heuval, 2005; Nicassio, 2008; Treharne, Kitas, Lyons et Booth, 2005); les taux de dépression se situent entre 17 % et 42 % (Ang, Choi, Kroenke et Wolfe, 2005; Evers, Kraaijaat, Geenen et Bijlsma, 1997; Frank et coll., 1988; Hawley et

Wolfe, 1993; Rosemann et coll., 2007), mais ne sont pas supérieurs à ceux qui souffrent d'autres affections chroniques (Newman, 1997). Chez les patients présentant des symptômes de dépression allant de modérément graves à graves, seulement 19 % ont parlé de dépression lors de leurs visites médicales, et les patients ont dû entamer la discussion avec leur professionnel de la santé chaque fois (Sleath et coll., 2008).

Figure 6. Proportion des personnes dépressives, par âge, Canada, 2000



Source : (Lagacé et coll., 2003)

La relation entre l'arthrite rhumatoïde et la dépression a reçu plus d'attention dans la littérature que la relation entre l'ostéoarthrite et la dépression (Wolfe, 1999). Certaines études ont permis de constater que les personnes souffrant d'arthrite rhumatoïde sont plus déprimées que les personnes souffrant d'ostéoarthrite (Dickens et coll., 2002). D'autres études n'ont toutefois pas constaté que le taux de dépression était supérieur ou qu'elle est plus courante chez les patients souffrant d'arthrite rhumatoïde (Hawley et Wolfe, 1993). Étant donné que la plupart des personnes arthritiques des Premières nations souffrent d'ostéoarthrite⁴ (Comité national de direction de l'enquête régionale sur la santé des Premières nations et des Inuits, 1999), la plupart des recherches disponibles ne portent pas sur l'affection dont la prévalence est la plus élevée chez les Autochtones. Bien que l'arthrite rhumatoïde ne soit pas notre principal intérêt dans l'étude des affections squeletto-musculaires chroniques, la recherche existante dans ce domaine peut être utile pour mieux comprendre les liens entre l'arthrite, l'ostéoarthrite et la dépression dans les communautés autochtones.

Par exemple, certains auteurs ont constaté que le temps écoulé depuis le début de la maladie est important. Treharne et coll. (2005) ont constaté que les patients dont le diagnostic d'arthrite

⁴ Des enquêtes comme l'ERSPNI s'intéressent « à l'arthrite et au rhumatisme », mais ne peuvent distinguer les différents types de diagnostics. La plupart des personnes interrogées qui déclarent souffrir d'arthrite souffrent très probablement d'ostéoarthrite (Comité, 1999; Comité national de direction de l'enquête régionale sur la santé des Premières nations et des Inuits, 1999).

rhumatoïde était établi étaient moins déprimés que ceux dont le diagnostic était récent (Treharne et coll., 2005). D'autres n'ont trouvé aucune différence en ce qui concerne la dépression entre les patients dont le diagnostic était récent et les patients diagnostiqués depuis longtemps quant à la détresse qu'ils éprouvent (Barlow et coll., 1999; Barlow, Cullen et Rowe, 2002; Evers et coll., 1997). Une étude a permis de constater que les indicateurs les plus importants de la gravité de la dépression étaient la douleur perçue, le manque de contacts sociaux, la limitation physique des membres inférieurs et supérieurs, l'âge et l'indice de masse corporelle (Rosemann et coll., 2007). Une autre conclut que le sexe, la douleur et le statut fonctionnel, l'impact de la maladie sur la vie quotidienne et le soutien social perçu sont associés à la détresse psychologique chez les patients diagnostiqués récemment (Evers et coll., 1997). Par contre, une autre étude ne conclut pas que la douleur est un indicateur important des symptômes de dépression. Les croyances sur l'acceptation de sa maladie et la fatigue exerceraient plus d'influence (Barlow et coll., 1999).

Contrairement à d'autres maladies chroniques, personne ne semble suggérer que la dépression joue un rôle étiologique dans le déclenchement de l'arthrite ou du rhumatisme (Rosemann et coll., 2007). La dépression est vue plutôt comme un fardeau de plus qui affecte l'adaptation à la maladie et ultimement son évolution (Burke et coll., 2002). La dépression comorbide chez les arthritiques s'est avérée un indicateur indépendant de la mortalité toutes causes confondues chez les patients souffrant d'une dépression persistante ou récurrente, ces derniers étant deux fois plus susceptibles de mourir que les patients ne souffrant pas d'une dépression (Ang et coll., 2005).

Une relation directe entre les marqueurs physiques de l'étendue ou de l'activité de la maladie et de la dépression n'a pas été constatée (Newman, 1997). La recherche a montré que les mesures physiologiques objectives de la maladie ne sont pas des indicateurs aussi robustes de l'incapacité que les facteurs psychologiques comme la dépression et la souffrance (Botha-Scheepers et coll., 2006; Kee, 2003; Lin et coll., 2003).

8.3 Thèmes communs

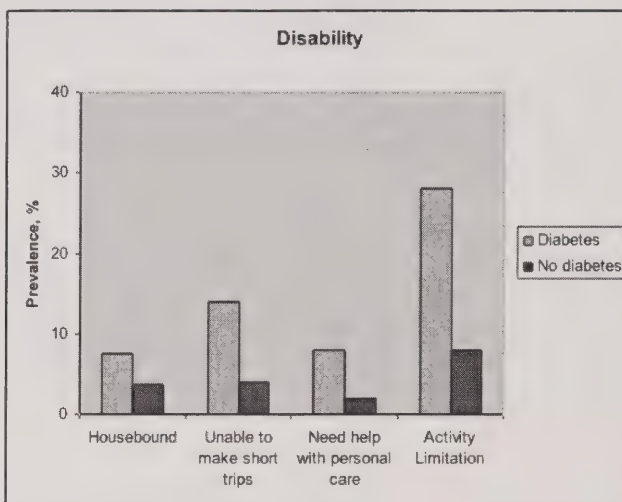
Comme le montre à l'évidence le texte précédent, il se dégage certains thèmes communs aux maladies chroniques qui ont un impact potentiel sur la santé mentale et qui peuvent prédisposer les personnes souffrant de maladies chroniques à la dépression. Les thèmes communs de l'incapacité, de la qualité de vie, de la perception de la maladie, de la perception de soi et du contrôle de soi seront abordés brièvement ci-après.

8.3.1 Degré d'incapacité

La relation entre le degré d'incapacité et la dépression s'étend à de nombreuses affections chroniques et a été explorée dans le contexte des différentes affections. La prévalence des affections chroniques a été associée à la limitation de l'activité chez les Autochtones et les Inuits au Canada : 24 % des personnes souffrant d'hypertension, 28 % de diabète, 33 % d'arthrite, 36 % d'une maladie cardiaque et 38 % d'un cancer ont déclaré un certain degré de limitation de l'activité (Centre des Premières Nations, 2004). On a constaté que les personnes souffrant d'une incapacité physique ont une moins bonne santé mentale (Barlow et coll., 1999; Cadman et coll., 1987; Cassileth et coll., 1984; Covington, 1991) et qu'une moins bonne santé mentale augmente l'incapacité (Patten, 1999; Penninx, Leveille, Ferrucci, van Eijk et Guralnik, 1999; Scott et coll., 2008; Sullivan et coll., 1999).

Une étude représentative en Ontario dans les années 1980 a permis de constater que les enfants ayant une maladie chronique et une incapacité associée avaient trois fois plus de risques de souffrir de troubles psychiatriques alors que les enfants ne souffrant que d'une affection chronique, mais sans incapacité, en avaient deux fois plus (Cadman et coll., 1987). Penninx, Beekman et coll. (1996) ont constaté que les maladies entraînant plus de handicaps fonctionnels, comme un accident vasculaire cérébral et l'arthrite, étaient plus souvent associées à une détresse psychologique que d'autres maladies chroniques causant moins de limitations fonctionnelles, comme le diabète, la maladie cardiaque et le cancer. Par contre, certaines études ont permis de constater que, chez les personnes vivant avec une maladie chronique, la diminution du fonctionnement physique et la progression de l'affection chronique n'étaient pas associées à une diminution proportionnelle de la santé mentale, probablement en raison d'un processus d'adaptation psychologique (Singer, Hopman et MacKenzie, 1999). Dans l'ensemble, la recherche a montré que les Autochtones souffrent davantage d'incapacité que la population canadienne en général (Centre des Premières Nations, 2005). Chez les adultes autochtones diabétiques, environ un quart d'entre eux éprouvent des limitations de l'activité causées par la maladie (Centre des Premières Nations, 2005). La figure 4 (ou 7?) présente les données sur les limitations de l'activité des Autochtones diabétiques, tel qu'indiqué dans l'ERSPNI de 1997.

Figure 7. Prévalence de l'incapacité chez les Autochtones diabétiques, en pourcentage



Source : Rapport national de l'enquête régionale sur la santé des Premières nations et des Inuits, 1999

Il a également été démontré que les troubles de santé mentale ont des effets négatifs sur l'incapacité, équivalents à ceux des affections physiques chroniques communes (Schonfeld et coll., 1997; Scott et coll., 2008). Une étude a permis de constater que la dépression chez les adultes plus âgés non handicapés souffrant d'une affection chronique augmente considérablement le risque d'incapacité, particulièrement pour l'arthrite et l'angine (Penninx et coll., 1999). Dans une étude de Scott, Von Korff et coll. (2008), les personnes souffrant de troubles mentaux étaient plus susceptibles d'être gravement handicapées que celles souffrant d'une affection physique (diabète, maladie respiratoire, maux de tête, maladie cardiaque, arthrite,

maux de dos ou de cou). Ils ont également constaté un effet synergétique entre la santé mentale et les affections physiques : les personnes souffrant de troubles mentaux et d'affections physiques étaient plus susceptibles d'être gravement handicapées que celles dans l'une ou l'autre condition seulement et la probabilité que cela se produise était plus grande que la somme des probabilités de chaque condition prise individuellement (Scott et coll., 2008). L'impact de l'association entre la maladie chronique et la santé mentale et la qualité de vie est directement associé à l'incapacité, ce dont il est question ci-après.

8.3.2 Impact sur la qualité de vie

La qualité de vie liée à la santé renvoie aux diverses influences de la santé, de la maladie et du traitement médical sur la façon dont une personne perçoit son fonctionnement et son bien-être (Jacobson, de Groot et Samson, 1997). La dépression, la maladie chronique et la qualité de vie sont étroitement associées, bien que la direction de la relation ne soit pas claire (Jacobson et coll., 1997). Des études sur des personnes diabétiques ont permis de constater qu'un diabétique souffrant d'une dépression a une moins bonne qualité de vie qu'un diabétique qui n'est pas déprimé (Goldney et coll., 2004; Gonder-Frederisk et coll., 2002; Jacobson, De Groot et Samson, 1994; Thommasen et coll., 2005). L'effet de la dépression sur la qualité de vie serait plus important que celui du diabète sur la qualité de vie (Goldney et coll., 2004). En ne considérant que l'impact du diabète sur la qualité de vie, on a constaté que les diabétiques ont une moins bonne qualité de vie que la population en général (Gonder-Frederisk et coll., 2002; Jacobson et coll., 1997; Mayou, Bryant et Turner, 1990; Rubin et Peyrot, 1999; Steed, Cooke et Newman, 2003).

Tableau 5. Indicateurs d'auto-détermination selon les sentiments de dépression ou de tristesse

% Fortement d'accord que...	Déprimé	
	Oui	Non
Je peux résoudre mes problèmes.	32.40%	38.50%
Personne ne m'incite à aller de l'avant dans la vie.	33.80%	41.00%
J'ai le contrôle sur ce qui m'arrive.	28.00%	31.1%
		(NS)
Je peux faire tout ce qui me vient à l'esprit	35.20%	43.20%
Je me sens souvent impuissant devant les problèmes de la vie.	7.40%	4.10%
Ce qui m'arrivera à l'avenir dépend surtout de moi	37.00%	37.6%
		(NS)
Je ne peux pas faire grand-chose pour changer plusieurs aspects importants de ma vie	10.60%	5.90%

Source : Enquête régionale longitudinale sur la santé des Premières Nations 2002-2003 : résultats pour les adultes, les jeunes et les enfants vivant dans les communautés des Premières nations

La raison en est probablement multifactorielle. Les diabétiques tendent à avoir un surplus de poids, à pratiquer moins d'activité physique et sont plus susceptibles de présenter des

comorbidités médicales (Gonder-Frederisk et coll., 2002; Jacobson et coll., 1997; Rubin et Peyrot, 1999; Thommasen et coll., 2005). Une meilleure qualité de vie est associée à des concentrations plus faibles de glucose dans le sang et à un contrôle métabolique strict (Jacobson et coll., 1997; Rubin et Peyrot, 1999). Au Canada, seulement une étude a permis de constater la relation entre la qualité de vie, le diabète et la dépression chez les Autochtones. Cette étude a permis de constater que les Autochtones ont une moins bonne qualité de vie que les autres et comptent un nombre moyen de jours de mauvaise santé mentale supérieur aux autres (Thommasen et coll., 2005). Comme l'information dans ce domaine porte surtout sur le diabète, la recherche sur l'impact des autres maladies chroniques et leur lien avec la santé mentale sur la qualité de vie sera importante dans le futur.

8.3.3 Perceptions de la maladie et de son état de santé

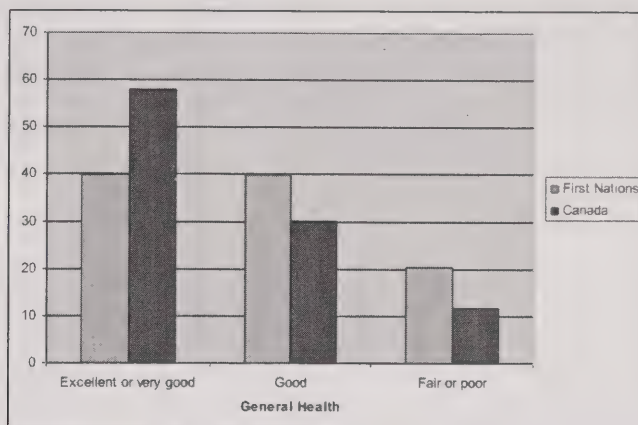
Les perceptions de la maladie et son acceptation influencent la présence de dépression chez les personnes souffrant d'une maladie chronique (Stanton et Revenson, 2007). Les perceptions de la maladie sont les croyances que les patients ont sur leur maladie, sur ses effets, sur les raisons de son déclenchement, sur sa durée et sur les possibilités de guérison ou de contrôle de la maladie (Botha-Scheepers et coll., 2006). Chez les personnes souffrant d'arthrite ou de rhumatisme, il a été démontré que les perceptions ont un grand impact sur les résultats (Botha-Scheepers et coll., 2006). Par exemple, un patient qui considère la maladie comme négative, incontrôlable et chronique est plus susceptible de moins bien s'adapter à la maladie, de présenter plus d'incapacité, d'être moins satisfait de sa vie et de souffrir de plus de dépression, d'anxiété, de douleur et de fatigue (Botha-Scheepers et coll., 2006; Kee, 2003; Nagyoca et coll., 2005; Treharne et coll., 2005). Par contre, une personne qui accepte sa maladie chronique est capable d'établir un nouveau cadre de vie et des objectifs raisonnables et de les réaliser (Nagyoca et coll., 2005). Arpin, Fitch et coll. (1990) ont constaté que le sens donné à la maladie était le facteur qui contribuait le plus aux différences d'adaptation observées chez les malades chroniques, quel que soit le type de maladie ou sa gravité (Arpin et coll., 1990). Ils ont ensuite suggéré que, puisqu'il n'existe aucune relation entre la gravité de la maladie et le sens donné à la maladie, les attitudes défavorables à l'égard de la maladie devraient servir à identifier les patients ayant besoin de services psychologiques (Arpin et coll., 1990).

La recherche sur des Amérindiens souffrant de rhumatisme et d'ostéoarthrite a permis de constater que les patients qui auraient dû avoir moins de capacités fonctionnelles et plus de douleur et de souffrance semble manquer du texte même en anglais (Kramer, Harker et Wong, 2002). La même recherche a conclu à l'absence de pensées négatives, ces dernières étant généralement associées à de moins bons résultats psychologiques et à une plus grande incapacité physique (Kramer et coll., 2002). McCubbin, Thompson et coll. (1993) ont constaté que les Amérindiens définissent le sens de l'incapacité dans le cadre d'un modèle plus général d'harmonie-inharmonie et considèrent les personnes souffrant d'une maladie chronique comme des membres actifs et précieux de la société et non comme des personnes différentes et stigmatisées.

On a également constaté que la perception de son état de santé est un facteur important de dépression chez les malades chroniques. Chez les Autochtones, la perception de son état de santé a été associée au suicide, l'indicateur le plus dramatique de la détresse. On a constaté que les pensées suicidaires sont plus fréquentes chez les personnes qui considèrent que leur santé est de

passable à mauvaise (38,4 %) que chez celles qui se déclarent en excellente santé (28,9%) (Centre des Premières Nations, 2005).

Figure 8. Santé générale des adultes des Premières nations et des autres adultes au Canada



Source: Enquête régionale longitudinale sur la santé des Premières Nations 2002-2003 : résultats pour les adultes, les jeunes et les enfants vivant dans les communautés des Premières nations

Chez les personnes souffrant d'arthrite rhumatoïde, l'optimisme est associé à moins d'anxiété, à moins de dépression et à plus de satisfaction à l'égard de la vie. Il y a également des indications que les personnes ayant une haute estime de soi, le contrôle de leur vie et de l'optimisme s'adaptent beaucoup mieux à la maladie chronique (Helgeson et Reynolds, 2002). L'optimisme a été associé à moins de douleur au début de l'arthrite et, fait intéressant, à davantage de douleur chez les personnes qui souffrent de la maladie depuis plus longtemps, reflétant probablement des attentes insatisfaites quant à l'amélioration de leur condition (Treharne et coll., 2005).

8.3.4 Image corporelle et estime de soi

Tout comme pour la perception de la maladie, on a constaté que l'estime de soi est associée à la santé physique et psychologique. Bien qu'aucune étude n'examine directement la relation entre l'estime de soi, la dépression et la maladie chronique chez les Autochtones, des études sur d'autres populations et touchant un ou plusieurs de ces aspects permettent de jeter les bases de cette relation. Par exemple, on a constaté qu'une faible estime de soi double le risque d'une dépression au cours de la vie (Nagyocsa et coll., 2005). Chez les personnes souffrant d'arthrite rhumatoïde, un niveau élevé d'estime de soi, accompagné d'une meilleure adaptation à la maladie, a été associé à moins de détresse psychologique (Nagyocsa et coll., 2005). L'image corporelle et l'estime de soi ont été particulièrement reliées à la santé psychologique chez les adolescents souffrant de maladies chroniques. Une étude de Wolman et coll. (1994) a permis de constater que l'image corporelle est le plus important indicateur du bien-être émotionnel chez des étudiants souffrant d'une affection chronique, indiquant qu'un bon sens de soi (image corporelle) ainsi que la cohésion et le soutien de la famille ont un impact plus important sur le développement émotionnel que le fait d'avoir une incapacité. Des adolescents de la Colombie-Britannique souffrant d'une maladie chronique ou d'une

incapacité sont plus susceptibles d'avoir une faible estime de soi que ceux qui n'ont pas de maladie chronique (17 % vs 5 %) (The McCreary Centre Society, 1994). Chez les jeunes autochtones handicapés, 78,2 % sont un peu moins susceptibles d'être d'accord ou fortement d'accord avec l'énoncé « J'aime comment je suis » comparativement à 85,6 % chez les jeunes sans incapacité. La différence est la plus prononcée chez les hommes, parmi lesquels ceux qui ont une incapacité sont d'accord ou fortement d'accord à 79,6 % avec l'énoncé, comparativement à 90,4 % de leurs homologues sans incapacité (Centre des Premières Nations, 2005). En plus de l'impression de confort et de la fierté à l'égard de son corps et de ses capacités personnelles, le sentiment d'avoir le contrôle de sa vie est également relié aux maladies chroniques et à la santé mentale.

8.3.5 Maîtrise

Le sens de la maîtrise renvoie au degré de contrôle que les gens estiment avoir sur leur vie (De Marco, 2000). La perception d'une faible maîtrise entraîne un sentiment d'impuissance et est associée à de moins bons résultats de santé et psychologiques (Daniel, O'Dea, Rowley, McDermott et Kelly, 1999; Gonder-Frederisk et coll., 2002; Sunday, Eyles et Upshur, 2001). Un sentiment de plus faible maîtrise peut être plus fréquent chez les malades chroniques à cause de la détérioration physique progressive et de l'apparition de symptômes imprévisibles commune à plusieurs maladies chroniques (Helgeson et Reynolds, 2002). Il est également plus probable que les malades chroniques et les personnes souffrant d'une incapacité physique soient confrontés à des problèmes difficiles à résoudre (Penninx et coll., 1996). Un sentiment de maîtrise élevé a été relié à un meilleur état de santé physique et psychologique chez les arthritiques (Barlow et coll., 2002; Burke et coll., 2002) et, chez les Autochtones du Canada, une bonne maîtrise a été associée à des niveaux normaux de lipides sanguins (Daniel, Rowley, Herbert, O'Dea et Green, 2001) et à de faibles niveaux de glucose (Daniel et coll., 1995). De même, une recherche américaine a constaté une relation inverse entre la douleur arthritique chez les Amérindiens et un bon sens de la maîtrise (Kramer et coll., 2002). Dans une autre étude, on a constaté que des personnes arthritiques ayant une bonne connaissance de leurs capacités avaient un seuil de tolérance à la douleur plus élevé alors que d'autres moins au fait de leurs capacités souffraient d'une plus grande incapacité physique, de plus de douleur, de plus de fatigue, de plus de dépression et d'anxiété et acceptaient moins bien leur état (Barlow et coll., 2002). Une étude chez des femmes ayant une incapacité physique a permis de constater que les femmes ayant de solides ressources personnelles (sens de la maîtrise, estime de soi ou endurance) avaient une bien meilleure capacité d'adaptation psychosociale à long terme, peut-être en raison de leur capacité à mieux vivre avec les épreuves et les difficultés familiales quotidiennes liées à leur maladie et à utiliser plus efficacement leurs ressources même si elles sont limitées (Dangoor et Florian, 1994).

Dans l'enquête régionale sur la santé de 2002-2003, on posait des questions associées de près à la maîtrise, et les résultats (voir le tableau 3 ou 5?) diffèrent selon qu'il y a dépression ou non (Centre des Premières Nations, 2005). Chez les adultes autochtones canadiens qui étaient déprimés, seulement 28 % croyaient qu'ils pouvaient contrôler ce qui leur arrivait, 7,4 % se sentaient impuissants à régler les problèmes de la vie et 10,6 % croyaient fermement qu'ils ne pouvaient pas faire grand-chose pour changer plusieurs aspects importants de leur vie (Centre des Premières Nations, 2005). L'enquête a permis de constater un modèle semblable chez les jeunes souffrant d'une incapacité (First Nations Centre, 2005).

Indicateurs d'auto-détermination selon les sentiments de dépression ou de tristesse

Source : Enquête régionale longitudinale sur la santé des Premières Nations 2002-2003 : résultats pour les adultes, les jeunes et les enfants vivant dans les communautés des Premières nations

Malheureusement, le sentiment d'impuissance et un faible degré de contrôle des aspects qui affectent leur vie sont courants dans de nombreuses communautés autochtones. Il s'agit en grande partie du résultat des impacts de la colonisation (Boston et coll., 1997; Grams et coll., 1996). Ce sentiment d'impuissance est depuis longtemps reconnu comme un important déterminant de la santé des Autochtones (Tsey et Every, 2000).

8.4 Comorbidité

8.4.1 *Cancer et diabète*

Le diabète semble accroître le risque de développer un cancer en général, car les changements dans les cellules affectées par le diabète peuvent faciliter la croissance des cellules cancéreuses, en particulier pour les cancers du foie, de l'œsophage, du côlon, du pancréas et d'autres cancers associés à l'obésité (Marrett, 2003). Les facteurs qui sont associés aux taux accrus de diabète comprennent le surpoids ou l'obésité, l'obésité abdominale, l'inactivité physique, les antécédents familiaux de diabète, un diagnostic de diabète gestationnel, la consommation élevée de gras saturés, l'hypertension, le cholestérol élevé, la diminution de la tolérance au glucose et l'ascendance autochtone, africaine, hispanique ou asiatique (Santé Canada, 2000). Comme on peut le voir dans cette liste, plusieurs facteurs de risque du diabète sont également des facteurs de risque du cancer, comme une alimentation riche en gras, l'inactivité et l'obésité. La prévalence du diabète dans la population autochtone est très élevée : 19,7 % chez les Premières nations, alors qu'elle est de seulement 4,9 % à 5,8 % dans la population canadienne en général. Selon l'enquête régionale sur la santé de 2002-2003, la plupart des Autochtones (78,2 %) ont reçu un diagnostic de diabète de type 2, 9,9 %, de diabète de type 1, et 9,8 % ont appris qu'ils étaient dans un état prédiabétique. Le diabète et l'intolérance au glucose sont les facteurs de risque les plus courants de maladies cardiovasculaires dans la population autochtone (Harris et coll., 2002), et c'est pourquoi il est si important de comprendre les liens entre ceux deux affections chroniques et l'interaction de leurs facteurs de risque. Ainsi, tout facteur de risque du diabète est un facteur de risque indirect d'une maladie cardiovasculaire.

8.4.2 *Diabète et maladies cardiovasculaires*

Le diabète est un facteur de risque de développer une maladie cardiovasculaire. Environ 70 % des décès des adultes diabétiques sont causés par une maladie cardiovasculaire (Daniel et coll., 2001; Gilmer et coll., 2005). Une étude menée dans des communautés indiennes en Arizona, en Oklahoma, au Dakota du Sud et au Dakota du Nord a permis de constater que le diabète est très fortement associé à la maladie coronarienne chez les Amérindiens (Howard et coll., 1995). L'hypertension est un facteur de risque de développer une maladie cardiovasculaire (Johnston, 1997), et sa prévalence est un peu plus élevée chez les adultes autochtones que dans la population en général (20,4 % comparativement à 16,4 %) (Centre des Premières Nations, 2005). D'autres rapports ont estimé que la prévalence de l'hypertension et des problèmes cardiaques chez les Autochtones dans les réserves était d'environ trois fois le taux de la population canadienne en général (Santé Canada, 2000). Les taux de lipides sanguins sont également associés au risque de maladie cardiaque et, fait intéressant, les bons taux de lipides sanguins ont

été associés à une bonne maîtrise et à peu de dépression chez les Autochtones canadiens (Daniel et coll., 2001). Chez les Autochtones, 50 % des répondants diabétiques ont signalé souffrir d'hypertension et 26 %, d'une maladie cardiaque; la prévalence était 3,3 et 3,9 fois celle des répondants non diabétiques (Young et coll., 2000). D'autres études ont permis de constater que 43 % des Autochtones diabétiques souffraient d'hypertension, comparativement à seulement 10 % chez les non-diabétiques (Santé Canada, 2000).

8.4.3 Ostéoporose et maladies chroniques

Une récente étude au Manitoba a permis de constater les associations suivantes entre les fractures ostéoporotiques et les maladies chroniques (Leslie, 2006) :

Le diagnostic de diabète est faiblement associé aux fractures ostéoporotiques après le contrôle de toutes les variables;

L'ethnicité est fortement associée à des taux supérieurs de fractures ostéoporotiques;

Plus grand nombre de maladies ambulatoires;

Problème d'abus d'intoxicants corrélé avec un plus grand risque de fractures tous sites confondus.

8.4.4 Déséquilibre de la santé et comorbidité

L'incidence que la maladie mentale peut avoir sur d'autres dimensions de la santé sera abordée à la fin de cette section.

Étant donné les effets débilants de la maladie mentale, il n'est pas étonnant d'apprendre que les personnes ayant une maladie mentale peuvent et ont souvent d'autres problèmes de santé. Pour les Autochtones qui considèrent la santé comme un équilibre entre la santé physique, mentale, émotionnelle et spirituelle ([CGIPN], 2005; Canada, 2006; Smye et Mussell, 2001), le déséquilibre d'une dimension de la santé peut causer un déséquilibre dans une autre. Par exemple, la maladie mentale peut entraver la capacité d'une personne d'adopter des comportements sains qui réduisent le risque de maladie physique (Lando, Williams, Williams et Sturgis, 2006). En outre, une mauvaise santé mentale peut entraver le traitement d'une maladie chronique (Lando et coll., 2006). Par contre, le fait de vivre avec une maladie physique chronique comme le diabète ou le cancer peut influencer négativement sur la santé mentale (Lando et coll., 2006). La santé émotionnelle peut également être entravée par la maladie mentale; le fait de s'identifier comme étant malade mental peut conduire à des sentiments d'aliénation et de désespoir (Lefley, 1990). Le lien entre la santé mentale et la santé spirituelle semble toutefois moins clair, bien que quelques Autochtones se soient rétablis d'une maladie mentale en favorisant la santé spirituelle (Storck et coll., 2000).

Il existe certaines données probantes sur la relation entre la maladie mentale et la santé physique dans la recherche portant sur la santé mentale des Autochtones. Une étude récente a permis de constater que la prévalence des maladies cardiovasculaires est deux fois plus élevée chez les Amérindiens ayant un diagnostic de dépression majeure au cours de leur vie que chez les autres (Sawchuk et coll., 2005). Dans la même étude, la prévalence des maladies cardiovasculaires était deux fois plus élevée chez les participants ayant un syndrome de stress post-traumatique (SSPT)

que chez les autres, et les facteurs de risque établis de maladie cardiovasculaire étaient également plus fréquents chez les participants ayant le SSPT (Sawchuk et coll., 2005). D'autres études ont relié l'abus d'intoxicants (particulièrement par injection) à l'augmentation des maladies transmissibles, comme le VIH et l'hépatite C, dans les populations autochtones (Callaghan, Cull, Vettese et Taylor, 2006; Spittal et coll., 2007).

L'abus d'intoxicants a également été relié à d'autres maladies mentales. Les personnes souffrant d'une maladie mentale sont plus à risque d'abuser des intoxicants, probablement à cause de leur désir d'« autoguérir » des symptômes psychologiques indésirables ou « d'engourdir » des sentiments douloureux (Phoenix Kasten, 1999). Comme nous l'avons mentionné dans la section précédente sur la dépendance, certaines personnes autochtones ont identifié leur abus d'intoxicants comme une tentative d'engourdir la douleur causée par les mauvais traitements et les sévices sexuels, la faible estime de soi, la perte de culture et d'identité, et l'histoire familiale de toxicomanie (Wardman et Quantz, 2005). Ainsi, les fardeaux sociaux des familles et des communautés peuvent influencer le bien-être mental de la personne. En retour, les comportements des personnes ayant une maladie mentale affectent les familles et les communautés (Warry, 1998). La section suivante montre comment les aidants naturels sont affectés par la maladie mentale et comment les fardeaux sociaux que sont la violence, l'abus d'intoxicants, l'incarcération et le suicide affectent la santé mentale de communautés entières.

Le lourd fardeau de la maladie chronique dans les populations autochtones, démontré dans les sections précédentes sur le « fardeau de la maladie », met en lumière la nécessité de comprendre les facteurs de risque de maladies chroniques dans les populations autochtones, car c'est avec cette compréhension des facteurs de risque communs que des stratégies pour améliorer la santé et le bien-être des Autochtones pourront être élaborées.

UNE APPROCHE FONDÉE SUR LE PARCOURS DE VIE : LES FACTEURS DE RISQUE DE MALADIES CHRONIQUES DANS LES POPULATIONS AUTOCHTONES AU CANADA

1. Introduction : adoption d'une approche fondée sur le parcours de vie

Afin de comprendre l'origine de l'augmentation des maladies chroniques dans les pays industrialisés tout au long du vingtième siècle, particulièrement pendant la période de l'après-guerre, les épidémiologistes, les professionnels de la santé et les décideurs ont ciblé les facteurs de risque au cours de la vie adulte (Kuh et Ben-Shlomo, 2004). Ainsi, le ciblage des comportements adultes et des facteurs liés au mode de vie, comme l'obésité, le tabagisme et le cholestérol élevé, est devenu le modèle qui prévaut pour la prévention des maladies chroniques et l'intervention (Kuh et Ben-Shlomo, 2004). Dans le monde industrialisé, cette approche et ses programmes ont été très fructueux pour alléger les problèmes associés aux maladies chroniques : les résultats de l'étude sur le cœur de Framingham sur 40 ans indiquent qu'aux États-Unis, plus de la moitié de la diminution de la mortalité causée par la maladie coronarienne observée chez les femmes et un tiers à la moitié de la diminution observée chez les hommes peut être attribuée aux changements des facteurs de risque au cours de la vie adulte (Sytkowski et coll., 1996). Malheureusement, l'amélioration globale des facteurs de risque au cours de la vie adulte et des maladies chroniques est limitée à certaines populations : alors que les taux de certaines maladies chroniques ont diminué dans les populations occidentales, les maladies chroniques sont une cause croissante de mortalité et de morbidité dans les populations vulnérables, comme les populations autochtones du Canada (Smeja et Brassard, 2000).

Un autre problème posé par l'approche des facteurs de risque au cours de la vie adulte est que, puisque les adultes sont ciblés pour changer leurs habitudes, la génération suivante grandit dans les mêmes conditions qui ont favorisé le développement de la maladie chronique des parents. Lorsque ces conditions ont leurs racines dans une population dont le statut socio-économique est bas, le risque de maladie augmente et l'application à la maladie chronique d'une approche fondée sur le mode de vie adulte est inefficace. Les disparités et les iniquités sociales en santé reconnues dans les communautés autochtones de tout le pays suggèrent qu'une approche fondée sur les facteurs de risque au cours de la vie adulte ne suffit pas. Les résultats d'études récentes sur les Autochtones renforcent un « cadre des déterminants de la santé », qui indique que des dispositions élargies en matière de bien-être social doivent être considérées pour réduire les disparités en santé (Newbold, 1998).

Au cours des 20 dernières années, l'épidémiologie des parcours de vie a émergé comme une solution de remplacement au modèle prévalent fondé sur les facteurs de risque décrit ci-dessus (Kuh, Ben-Shlomo, Lynch, Hallqvist et Power, 2003). L'épidémiologie des parcours de vie a été définie comme l'étude des effets à long terme des expositions physiques ou sociales durant la grossesse, l'enfance, l'adolescence, la jeune vie adulte et la vie adulte sur la santé du développement et les risques de maladie plus tard (Kuh et coll., 2003). L'épidémiologie des parcours de vie offre un moyen de conceptualiser la façon dont les déterminants de la santé biologiques et socio-environnementaux vécus à différentes étapes de la vie peuvent influencer différemment sur le développement de maladies chroniques (Moore et Davies, 2005). L'avantage de cette perspective est qu'elle élargit les modèles conventionnels des risques pour la santé fondés sur les modes de vie adultes en reconnaissant que les facteurs psychologiques et

physiologiques survenant tout au long de la vie peuvent affecter divers résultats, du bien-être général au fonctionnement physique et au développement de maladies chroniques (Ben-Shlomo et Kuh, 2002, 1996; Darnton-Hill, Nishida et James, 2004). L'un des principaux atouts de cette approche est qu'elle montre également comment les risques qui surviennent tout au long de la vie peuvent être déterminés, corrigés ou modifiés au cours de la longue période nécessaire au développement d'une maladie chronique (Lynch et Smith, 2005). Parallèlement, « une perspective axée sur le parcours de vie permet de voir les différences en matière de santé parmi les populations, les groupes d'âge, etc., comme le résultat d'une accumulation de désavantages matériels qui reflètent en grande partie des circonstances économiques et sociales différentes » (Darnton-Hill et coll., 2004). Ce n'est qu'après avoir considéré la maladie comme un aspect du parcours de vie de la personne que « la prévention et le contrôle de la maladie chronique (...) peuvent être intégrés intimement dans la vie quotidienne normale » (Darnton-Hill et coll., 2004) et soutenus afin de favoriser la santé des communautés. Ainsi, les stratégies qui visent les facteurs de risque doivent tenir compte continuellement des « facteurs économiques, sexuels, politiques, comportementaux et environnementaux sous-jacents qui favorisent ces risques de maladie » (Darnton-Hill et coll., 2004) dans tous les groupes d'âge et d'une génération à l'autre.

L'approche fondée sur le parcours de vie ajoute également au modèle des facteurs de risque au cours de la vie adulte une meilleure compréhension du moment et de la durée d'exposition aux risques en mettant l'accent sur ces aspects (Ben-Shlomo et Kuh, 2002). Plusieurs modèles ont été utilisés pour déterminer l'importance du temps dans le développement de la maladie et ont servi de base aux cadres théoriques sous-jacents des études fondées sur le parcours de vie. Le modèle de la période critique suppose que l'exposition à une certaine période, habituellement tôt dans la vie, a un effet permanent qui demeure relativement stable tout au long de la vie. Ce modèle peut être élargi en analysant l'interaction de ces expositions précoces avec des expositions plus tard dans la vie. Un autre modèle possible est celui de l'accumulation des risques qui postule que le développement de la maladie est le résultat d'expositions et de dommages cumulatifs au cours de la vie à un certain seuil. Enfin, le modèle de cheminement suggère qu'une exposition augmente la probabilité d'autres expositions, qui peuvent éventuellement déclencher une maladie. Bien que la durée, l'ampleur et l'impact de l'exposition soient différents pour chacun de ces modèles, ils traitent tous de l'importance de tenir compte de l'interconnexion entre le temps et le risque de maladie pour obtenir une meilleure compréhension de l'étiologie des maladies chroniques. En plus des avantages qu'offre le parcours de vie pour l'organisation des méthodes d'investigation et de recherche, une approche fondée sur le parcours de vie offre un outil efficace aux décideurs, car, comme l'indique l'Organisation mondiale de la santé (OMS), une telle approche peut aider à déterminer les politiques et les méthodes de prévention les plus efficaces et éventuellement les plus fructueuses pour combattre les maladies chroniques (OMS, 2005).

1.1 Perspective du parcours de vie et santé des Autochtones

Le fardeau des maladies chroniques dans les populations autochtones est un grave problème de santé publique. Comme les taux de morbidité et de mortalité associés aux maladies chroniques continuent de montrer des signes de croissance dans ces populations (Smeja et Brassard, 2000), une nouvelle approche pour étudier les tendances des maladies et faciliter des interventions positives est nécessaire. Tel que mentionné ci-dessus, la perspective du parcours de vie offre un modèle théorique approprié à cette fin. De plus, l'approche fondée sur le parcours de vie est complémentaire des perspectives autochtones sur la santé. Premièrement, une perspective du

parcours de vie offre aux chercheurs un outil pour intégrer le savoir scientifique, culturel et sociologique d'une manière significative; cette fusion est nécessaire pour satisfaire à la fois les exigences scientifiques et culturelles de la recherche sur la santé des Autochtones.

Deuxièmement, la recherche sur le parcours de vie aborde la santé d'une manière holistique (Lynch et Smith, 2005), une approche complémentaire aux conceptions autochtones de la santé et du bien-être qui englobent les aspects physique, mental, émotionnel et spirituel (Bartlett, 1998). Ces conceptions sont illustrées par une citation tirée de l'enquête régionale sur la santé des Premières Nations et des Inuits de 2002-2003 : « Le cycle de vie du cercle d'influences connecte les expériences et le bien-être des nourrissons aux expériences et au bien-être des enfants, des jeunes, des jeunes adultes, des parents, des grands-parents et des aînés, d'un point de vue individuel, familial, communautaire et autochtone. » (Centre des Premières Nations, 2005).

La crise de l'état de santé des Autochtones d'aujourd'hui se complique de problèmes profondément enracinés dans les disparités sociales (Adelson, 2005), et c'est pourquoi on ne croit pas que l'évaluation des risques ou les recommandations sur la santé réduiront le fardeau de la maladie si on ne privilégie pas une compréhension parallèle de l'importance du changement social. L'épidémiologie du parcours de vie offre un cadre conceptuel pour intégrer les facteurs de risque sociaux et biologiques (Kuh et coll., 2003) : elle permet au chercheur et à la communauté de déterminer les modèles de risques dominants dans la région et de cibler leur éradication avant qu'une accumulation de ces risques devienne un problème. Parce qu'une recherche réalisée « par et pour » les Autochtones et reflétant les perspectives autochtones est la plus susceptible d'améliorer la santé des Autochtones du Canada (O'Neil, Reading, Bartlett, TK et J, 1999), la reconnaissance des valeurs sociales et culturelles du parcours de vie est également prometteuse. À mesure que les populations autochtones acquièrent les ressources nécessaires à leur responsabilisation, les applications de l'épidémiologie du parcours de vie pourraient être utilisées pour formuler de nouvelles recommandations stratégiques fondées sur la prévention.

1.2 Application de l'approche fondée sur le parcours de vie

En étudiant le développement d'une personne et les expositions aux risques tout au long de sa vie, en termes de conditions biologiques et de facteurs socio-économiques, la structure de la morbidité chronique peut être mieux comprise. Ainsi, les facteurs de risque notés dans la littérature seront abordés pour le stade de vie particulier où ils ont un grand impact ou auquel une personne court le risque le plus élevé de développer une maladie chronique. Cette section commencera toutefois par une discussion des facteurs de risque communautaires et de grande portée qui influencent la santé et le bien-être tout au long de la vie. Ces facteurs de risque qui se recoupent sont d'abord abordés pour aider à établir le contexte et mettre en lumière les facteurs sous-jacents qui influencent la santé et le bien-être de la population autochtone. Ensuite, cette section examinera les différentes étapes de la vie. Naturellement, nous commencerons par les facteurs de risque prénatals. Suivra un approfondissement des facteurs de risque à la naissance, au cours de la petite enfance, de l'enfance, de l'adolescence et de la vie adulte. Il s'agit d'un ordre naturel et logique qui suit la trajectoire de la vie et le parcours chronologique de l'exposition au risque et du développement de la maladie. Bien que cette séparation des différentes étapes de la vie soit importante, il est également important de se rappeler que les nombreux facteurs de risque sont présents à plusieurs étapes de la vie. Afin d'éviter le

dédoulement, l'attention sera portée sur le moment de l'exposition et l'impact des facteurs de risque sur la santé et le développement à long terme.

La discussion sur les facteurs de risque, c'est-à-dire les facteurs biologiques, sociaux, économiques, environnementaux et politiques qui influent sur la santé de la personne, la santé des communautés, des populations et des générations, sera également abordée sous l'angle des « déterminants de la santé ». Cela permettra une discussion générale sur le contexte complexe des facteurs de risque chez les populations autochtones au Canada et partout dans le monde.

2. Facteurs de risque communautaires

Les facteurs de risque « communautaires » sont définis ici comme ceux qui ont un impact sur la santé aux différentes étapes de la vie, au-delà de la durée de vie d'un individu, à travers une génération et entre les générations. Ces facteurs à niveaux multiples sont un ajout important au modèle de facteurs de risque conventionnel : il est important d'aborder les facteurs de risque comme des éléments qui agissent au sein d'une génération et d'une génération à l'autre parce que cela favorise la prise en compte des enjeux de santé collectifs et des interconnexions entre la santé et la société. Nous miserons sur les discussions du chapitre précédent, l'environnement de la recherche sur la santé des Autochtones, qui ont démontré comment les efforts du gouvernement canadien pour opprimer les cultures, les traditions et les structures communautaires des populations autochtones ont causé un traumatisme collectif et une souffrance globale, et ont donné lieu à des problèmes de santé dans de nombreuses communautés autochtones ([CGIPN], 2005; Kirmayer, Brass et Tait, 2000). En plus de l'histoire sociale, politique, culturelle et intellectuelle de la santé des Autochtones, cette section examinera les facteurs de risque communautaires associés au statut socio-économique et à la géographie. Cet aspect est important parce qu'il permettra une discussion approfondie des déterminants sociaux de la santé qui agissent sur les communautés et influent sur leur santé et leur bien-être. Cela est particulièrement important dans le cadre de la prévalence des maladies chroniques, car il a été démontré que les problèmes sociaux, économiques et environnementaux ont un effet considérable sur le risque de maladie et la mortalité (NSW Health, 2006).

2.1 Facteurs de risque socio-économiques

La mauvaise santé des Autochtones a été associée « aux effets corrosifs de la pauvreté et de la marginalisation économique » (Kirmayer et coll., 2000), mais ces déterminants sociaux de la santé ont eux-mêmes été décrits comme des conséquences directes et indirectes des politiques historiques de colonisation ([CGIPN], 2005; King, 2006). Ainsi, les risques associés à la colonisation sont interreliés et indissociables des risques posés par le désavantage économique (Beauchamp et coll., 2004; Canada, 2003; Carson, Dunbar, Chenhall et Bailie, 2007; Reading, Kmetc et Gideon, 2007). Malheureusement, les peuples indigènes du monde entier sont assujettis de façon disproportionnée au risque de maladie à cause de déterminants sociaux comme la pauvreté, le faible revenu et l'absence de logement adéquat ([CGIPN], 2005; Adelson, 2005; Beauchamp et coll., 2004; Canada, 2006; Canada, 2003). Comme « l'inégalité sociale, mesurée au niveau de la population ou de l'individu, est la seule condition principale d'une mauvaise santé » (Geyorfi-Dyke, 2008), ce désavantage social met en lumière les risques pour la santé et le bien-être des Autochtones au Canada. L'impact éventuel des facteurs socio-économiques est encore plus évident si l'on considère le fardeau imposé au développement biologique des personnes, car ces désavantages s'accumulent tout au long de la vie et à travers

les générations (Adelson, 2005; Beauchamp et coll., 2004; Carson et coll., 2007; Marmot et Wilkinson, 1999; Warry, 1998). C'est dans cette perspective que l'influence particulière de la pauvreté et du statut socio-économique, de même que du logement, sur le développement des maladies chroniques est abordée ci-après.

2.1.1 Faible statut socio-économique et pauvreté

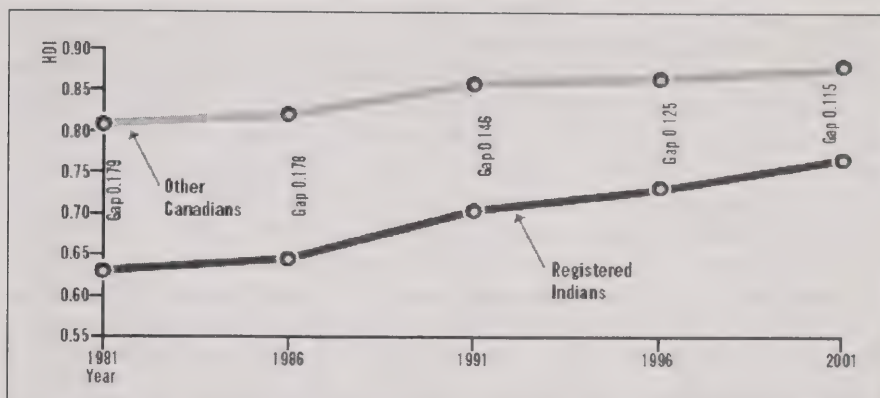
Bien que la pauvreté des enfants ait été abordée brièvement dans la section sur les « facteurs de risque dans la petite enfance », les impacts de la pauvreté et du statut socio-économique sur les maladies chroniques sont repris ici pour mettre l'accent sur la nature intergénérationnelle et cyclique de la pauvreté : la pauvreté des enfants est la pauvreté des familles, la pauvreté des communautés, la pauvreté des générations. En d'autres mots, la pauvreté n'affecte jamais une seule personne, une seule fois, mais elle constitue un problème qui transcende l'âge, le temps et l'espace.

Définition et description de la pauvreté des Autochtones au Canada

Bien que la pauvreté puisse être (et ait été) décrite et définie de plusieurs manières différentes, elle est souvent classifiée en fonction de son caractère extrême. Ainsi, elle est souvent qualifiée de pauvreté extrême, modérée et relative. La pauvreté extrême, c'est lorsque les ménages (ou les personnes) ne peuvent pas répondre à leurs besoins fondamentaux et assurer leur survie. La pauvreté modérée, c'est lorsque les besoins fondamentaux sont à peine satisfaits. Enfin, la pauvreté relative, c'est lorsque le revenu du ménage est inférieur au revenu moyen national (OMS, 2008). Ainsi, la pauvreté relative est souvent mesurée en termes de « faible revenu » et de « faible statut socio-économique ». Au Canada, la pauvreté relative (ou faible revenu) est mesurée en fonction du seuil de faible revenu (SFR) établi par Statistique Canada (Ross, Shillington et Lochhead, 1994; Statistique Canada, 1999). Malgré l'existence d'expériences, de mesures et d'approches variées, il est clair que tous les types de pauvreté affectent défavorablement la santé. Ainsi, cette section présentera le lien général entre la pauvreté et les maladies chroniques, mais examinera tout d'abord la prévalence de la pauvreté dans la population autochtone du Canada.

Pour mesurer et comparer la qualité de vie entre les différents pays ou les populations, l'ONU a établi l'Indice de développement humain (IDH). Cet indice a été appliqué au Canada dans le but de comparer la qualité de vie et le bien-être des populations autochtones et non autochtones au Canada (AINC, 2004). Le Canada a régulièrement été classé selon l'IDH comme l'un des cinq premiers pays au monde. Toutefois, lorsque le classement de l'IDH est contrôlé pour l'ascendance autochtone, la population autochtone du Canada se classe à un choquant 78^e rang (Blackstock, 2005). Cela met en lumière l'analogie souvent mentionnée selon laquelle les Autochtones au Canada vivent dans des conditions propres au tiers monde dans l'un des premiers pays du monde (O'Neill, 2007). Cela est démontré par l'écart entre la ligne bleue et la ligne rouge dans la figure 1 ci-dessous. La figure démontre également que : 1) le résultat de l'IDH pour les Indiens inscrits et celui des autres Canadiens ont tous les deux augmenté de 1981 à 2001, 2) l'écart entre les résultats de l'IDH a diminué (de 0,179 en 1981 à 0,115 en 2001), et 3) sans équivoque, un large écart demeure entre la santé des Indiens inscrits et celle des autres Canadiens.

Figure 1. Indice de développement humain pour les Indiens inscrits et les autres Canadiens, 1981-2001



Source (AINC, 2004)

En plus de l'IDH, les statistiques sur les revenus et les taux de pauvreté illustrent le faible statut socio-économique de nombreux Autochtones au Canada. Par exemple, « 47,2 % des Autochtones de l'Ontario gagnent moins de 10 000 \$ par année (Ontario Federation of Indian Friendship Centres, 2004). Les statistiques pancanadiennes montrent également que les Autochtones sont économiquement défavorisés : 73,4 % des Autochtones gagnent moins de 20 000 \$ par année et le revenu moyen est de 15 699 \$ par rapport à 25 414 \$ dans le reste du Canada (Sin et coll., 2002). Les données recueillies en milieu urbain démontrent que ce sous-ensemble de la population autochtone est considérablement défavorisé comparativement aux citoyens non autochtones. Par exemple, une étude de 2000 signale que les Autochtones vivant en milieu urbain sont deux fois plus susceptibles de vivre dans la pauvreté que les non-autochtones (Lee, 2000). De plus, bien que ne représentant que 1,5 % de la population urbaine, les Autochtones représentent 3,4 % de la population pauvre (Lee, 2000).

Pauvreté et santé

Comme cela a été démontré ailleurs (et il en sera question dans les propos sur les étapes de la vie), les facteurs de risque traditionnels comme le tabagisme, l'hypertension, l'obésité et un mauvais régime alimentaire sont des facteurs de risque courants et préoccupants du développement des maladies chroniques. Toutefois, ces facteurs de risque n'expliquent qu'une fraction de l'incidence et de la prévalence des maladies chroniques et de la mortalité causée par ces maladies dans les populations autochtones. Par exemple, la recherche a continuellement montré que le statut socio-économique peut avoir un impact considérable sur la prévalence de la maladie et la mortalité (Marmot, 1987; Smith, Hart, Blane, Gillis et Hawthorne, 1997; Syme et Browne, 2002; Syme, 2004; van Rossum, 2000) : il existe « d'abondantes données montrant un lien entre la pauvreté et la mauvaise santé » (Marmot et Wilkinson, 1999). Par exemple, il a été noté que « plus le niveau socio-économique est élevé, plus le taux de mortalité est bas » (Marmot, 2005). La recherche a conclu que les facteurs de risque traditionnels chez les adultes ne représentent que 25 à 35 % de la mortalité associée à ce « gradient social » (Marmot, 2005; Syme, 1989). Bien que tous les aspects de cette association restent à déterminer, il sera question

ci-après de la recherche documentant la relation entre la pauvreté et la prévalence des maladies chroniques et de la mortalité.

La pauvreté augmente le risque d'une personne, d'une famille et d'une communauté de développer des maladies chroniques, des complications et de mourir (OMS, 2008), et ce, parce que la privation matérielle, des conditions de vie malsaines (p. ex. un logement inadéquat et une alimentation insuffisante) et le manque d'accès aux services de soins de santé prédisposent les personnes ayant un faible statut socio-économique au développement de maladies chroniques et à l'adoption de comportements à risque tout au long de leur vie (NSW Health, 2006). Par exemple, l'OMS note que « les pauvres et les gens moins instruits sont plus susceptibles de consommer des produits du tabac et des aliments énergétiques et riches en gras, d'être inactifs physiquement et d'être en surpoids ou obèses » (OMS, 2008). Le stress psychologique est également considéré comme un facteur important de la mauvaise santé chez les pauvres. Des chercheurs réputés comme Marmot et Syme parlent de ce stress comme de la perte de contrôle sur sa destinée et, par le fait même, de la capacité d'affronter les forces qui affectent la vie quotidienne, ce qui est un élément clé du lien entre le statut socio-économique et la santé (Marmot, 2005; Marmot, 1998; Syme, 1998; Syme, 1989; Syme, 2004). Cette théorie a été soutenue par la recherche qui a constaté que « le contrôle de la destinée » est inférieur dans les groupes de statut inférieur (Marmot, 2005). Des études neuroendocrinologiques ont également démontré que le manque de contrôle sur les circonstances de la vie génère une dose de stress sur le corps, qui peut éventuellement causer le développement d'une variété de maladies et d'affections, particulièrement le diabète insulino-dépendant, les maladies cardiovasculaires (Mc Ewan, 1998; McEwen, 2006), l'alcoolisme et le suicide (Syme, 1998). En plus de causer du stress et la perte de contrôle sur son avenir, le stress associé aux finances, au manque d'accès à des aliments sains (ou à des aliments tout court), au manque d'accès aux soins de santé de base, aux mauvaises conditions de vie et à l'incapacité de répondre aux besoins fondamentaux démontre la corrélation entre un faible statut socio-économique et la santé (Behrman, 1995). Bien que le fait que le statut socio-économique de nombreux Autochtones ait augmenté ces dernières années soit encourageant, le fossé demeure entre les populations autochtones et non autochtones au Canada (voir la figure 1 ci-dessus). Il en va de même pour les autres populations indigènes du monde : les populations indigènes des pays industrialisés sont « une minorité exclue socialement dans leur pays » (Marmot, 2005) et elles sont « surreprésentées dans la strate du faible statut socio-économique » (Valery, 2006). L'impact direct de la surreprésentation des Autochtones parmi les niveaux de vie de faible statut socio-économique sur la santé mentale, le cancer et les maladies respiratoires, donnés comme exemples de maladies chroniques, est présenté ci-après.

Les disparités socio-économiques et, plus particulièrement, leur relation avec une perte de contrôle de la destinée sont un important facteur de risque de problèmes de santé mentale (Canada, 2006; Warry, 1998). Comme Warry (1998) l'explique, les problèmes d'alcoolisme et de violence familiale chez les Autochtones sont profondément enracinés dans la perception qu'ils ont de manquer de contrôle sur leur vie. Syme (2004) suggère qu'un manque de « contrôle de la destinée » contribue aux problèmes de santé communautaire et interfère avec le désir des Autochtones d'assumer la responsabilité de leur santé et de leur bien-être (Warry, 1998). Par exemple, certaines personnes souffrant d'une grave maladie mentale ont indiqué que la pauvreté a un impact débilisant sur leur estime de soi, leur réseau social, leurs activités de loisirs et leur capacité de répondre à leurs besoins fondamentaux, de visiter les membres de leur famille et

d'établir des relations intimes (Wilton, 2004). Le caractère débilitant de la pauvreté est souvent considéré comme plus difficile à accepter que le diagnostic ou le traitement de la maladie. Et les problèmes associés à la pauvreté tendent à exacerber l'intensité, la persistance et les effets de la maladie (Lee, 2000).

La relation entre le statut socio-économique et le risque de cancer est très complexe. La recherche actuelle indique que le fait d'avoir un statut socio-économique supérieur peut prédisposer les gens à certains types de cancers (p. ex. poumon, sein, colorectal) alors qu'un statut socio-économique inférieur peut augmenter le risque de développer d'autres types de cancers (p. ex. estomac, foie et cerveau) (Brown et Lipscomb, 2006). Les comparaisons entre les pays industrialisés et les pays en développement, qui ont conduit à ces conclusions, sont transposables à l'étude sur le risque de cancer au Canada, car les populations autochtones ont été comparées aux sociétés qui vivent dans des pays en développement (Epstein, 1982). Et comme le montre la prévalence du cancer dans les populations autochtones au Canada, les « cancers du tiers monde » sont généralement plus courants chez les Autochtones que les « cancers occidentaux ». Cela suggère que le ciblage du statut socio-économique comme facteur de risque aidera à réduire le risque de cancer chez les Autochtones. Il est également important de s'attarder au rôle que le revenu joue sur les difficultés liées au cancer dans les populations autochtones et à ses liens avec le taux de survie au cancer : on a constaté qu'un faible statut socio-économique conduit à des taux de survie inférieurs ainsi qu'à une augmentation des décès par le cancer (Marrett, 2003).

On a également constaté que le statut socio-économique influe sur la prévalence du diabète. Une étude de 2003 a montré que les cas de diabète étaient principalement regroupés dans les quartiers de Winnipeg où on retrouve un faible statut socio-économique, une piètre qualité de l'environnement, des modes de vie à risque et une grande concentration d'Autochtones (Green, Hoppa, Young et Blanchard, 2003). L'étude concluait que l'éducation et le revenu sont des indicateurs de diabète plus importants que le statut autochtone, suggérant que le statut socio-économique, plutôt que les facteurs génétiques, est responsable de la grande prévalence du diabète (Green et coll., 2003). Malgré les études qui montrent des corrélations possibles entre la pauvreté et la santé, il est important de se rappeler que la pauvreté à elle seule ne détermine pas la santé d'une personne ou de la population. Ainsi, la nature complexe de la relation entre la pauvreté et la maladie, notamment les maladies chroniques, dans les populations autochtones reste à déterminer et devrait être au centre de la recherche à venir. Elle devrait comprendre un examen de la pauvreté comme facteur de risque de développement des maladies chroniques, et un examen des maladies chroniques comme facteur de risque de pauvreté. Voici en ce sens une citation de l'OMS – maladies chroniques et pauvreté :

Les maladies chroniques infligent un énorme fardeau économique direct et indirect aux pauvres et réduisent de nombreuses personnes et leur famille à la pauvreté. En outre, le décès ou la maladie des parents ou des aidants naturels peut conduire à l'appauvrissement des enfants et/ou de la communauté. Les connaissances actuelles sous-estiment les répercussions des maladies chroniques sur la pauvreté et le potentiel de la prévention des maladies chroniques et de la promotion de la santé sur la diminution de la pauvreté. (OMS, 2008)

Comme cette citation le met en lumière, la prévention des maladies chroniques et les interventions ciblant les déterminants sociaux sous-jacents de la santé pourraient améliorer grandement les taux de pauvreté et le bien-être général des Autochtones.

2.1.2 Logement

Aux problèmes de revenu s'ajoutent les problèmes de logement, problèmes qui sont interreliés. Comme pour le revenu, les désavantages liés au logement ont été reconnus comme ayant des impacts sur la santé (Carson et coll., 2007). Les désavantages liés au logement peuvent être mesurés et sont exprimés de différentes manières. Par exemple, les sans-abri sont souvent considérés comme présentant un désavantage extrême, alors que le logement sous la norme et la qualité d'une maison sont des désavantages plus modérés. Cette section porte sur le gradient des désavantages liés au logement que subissent les Autochtones au Canada.

Itinérance chez les Autochtones au Canada

Selon la terminologie de la pauvreté, l'itinérance a été caractérisée en fonction de son caractère extrême : itinérance absolue, relative ou à risque. Selon ces paramètres, l'itinérance absolue se définit ainsi :

« Personnes sans logement qui peuvent ou non vivre dans la rue; certaines peuvent compter sur les refuges d'urgence, un logement transitoire, les amis et la famille. S'y ajoutent les "surfeurs de divan". Ce sont des personnes sans logement qui dorment dans différentes maisons lorsqu'elles le peuvent. » (Helin, 2002)

L'« itinérance relative » renvoie à la situation des personnes qui ont un logement physique, mais ce dernier ne répond pas aux critères de base en matière de santé et de sécurité (Hwang, 2001). Les personnes à risque d'itinérance sont celles qui sont défavorisées sur le plan socio-économique et qui ont de la difficulté à payer le loyer (Helin, 2002). Le pauvre qui travaille est un bon exemple de ce groupe, car continuellement « il vit au bord d'un précipice qui, à tout moment, peut le faire plonger dans l'itinérance » (Plumb, 2000). On a également qualifié l'itinérance de « situationnelle » (ou temporaire), « épisodique » et « chronique » (long terme) (Beavis, Klos, Carter et Douchant, 1997). Bien que différente du jargon utilisé dans la littérature sur la pauvreté, cette catégorisation est plus intuitive que les termes « absolue » et « relative ».

La littérature démontre que l'itinérance est vécue par les populations indigènes du monde entier, bien qu'elle ne se présente pas de façon égale dans toutes les populations indigènes. Parmi les populations indigènes comptant un nombre disproportionné d'itinérants, mentionnons les anciens combattants amérindiens, les indigènes du territoire du nord de l'Australie et les Autochtones des grandes villes du Canada (Carson et coll., 2007; Hwang, 2001; Kaspro et Rosenheck, 1998). La littérature documente les tendances de migration, qui ont conduit à une augmentation du nombre d'Autochtones urbains et de sans-abri autochtones. Considérons la citation suivante :

« Chez les Autochtones, les tendances de migration à la hausse de la réserve aux centres urbains ont conduit à une augmentation radicale du nombre d'Autochtones résidant maintenant de façon permanente dans les centres urbains. Les données probantes anecdotiques et statistiques indiquent que la représentation des Autochtones parmi les sans-abri est de plus en plus disproportionnée dans la plupart des grandes villes canadiennes et qu'ils ont des besoins culturels uniques. Personne ne peut dire avec

certitude l'étendue du problème ou chiffrer avec exactitude la population autochtone itinérante. » (Helin, 2002)

Toutefois, à Toronto, les médias ont signalé que 25 % des sans-abri de Toronto sont d'ascendance autochtone (Wente, 2000). Sachant que la population autochtone ne représente qu'environ 2 % de la population totale de Toronto, la représentation disproportionnée des Autochtones parmi la population itinérante à Toronto est encore plus évidente (Wente, 2000). D'autres chiffres indiquant que les Autochtones constituent 15 % de la population itinérante mettent aussi en lumière le nombre disproportionné de sans-abri autochtones dans la ville (Mayor's Homelessness Action Task Force, 1999). Comme ces chiffres ne comprennent pas les populations projetées ou à risque, on croit que le nombre d'itinérants autochtones pourrait être de 8 000 (Mayor's Homelessness Action Task Force, 1999).

Afin d'obtenir un meilleur portrait de la population itinérante autochtone, Street Health a réalisé plusieurs sondages sur la population itinérante et a établi des liens solides avec cette communauté. Le sondage de 2007 de Street Health (le plus récent) a permis de constater que les Autochtones représentaient 15 % de la population itinérante, un nombre impressionnant quand on considère que le recensement de 2001 indique que les Autochtones représentent seulement 0,5 % de la population en général (Street Health, sous presse). L'information obtenue en sondant cette population est résumée ci-après. On recommande également aux lecteurs intéressés de consulter le *Street Health Report 2007 Research Bulletin #3: Aboriginal People & Homelessness* (Street Health, sous presse). La démographie et la composition de la population autochtone sondée par Street Health sont décrites par les chiffres suivants : 1) l'âge moyen est de 38 ans et l'étendue est de 25 à 49 ans; 2) 31 % sont nés à Toronto; 3) 20 % s'identifient comme lesbiennes, gais, bisexuels ou transsexuels; 4) 39 % ont complété l'école secondaire et 15 % d'entre eux ont un diplôme collégial ou universitaire; 5) 33 % vivent avec 2 400 \$ ou moins par année; 6) 20 % sont employés – 4 % travaillent à temps partiel et 16 % indiquent un travail occasionnel ou à la pièce, mais personne n'indique travailler à plein temps; 7) les répondants ont été sans abri pendant une moyenne de 4,7 ans; 8) 15 % indiquent une langue autochtone comme langue maternelle; et 9) 27 % disent avoir une carte d'inscrit. Alors que le rapport produit par Street Health démontre que la représentation des Autochtones dans la population itinérante est disproportionnée, la littérature montre que les Autochtones présentent un risque accru de devenir des sans-abri (Helin, 2002). Telle que définie dans la Greater Vancouver Regional District (GVRD) Aboriginal Homelessness Study 2003 (Dappleton Research Team, 2003), une personne autochtone urbaine présente un risque de devenir un sans-abri si elle consacre plus de 25 % de son revenu au logement, si elle souffre d'une crise de vie grave, si elle risque de perdre son logement, si le revenu du ménage est sous le seuil de faible revenu de Statistique Canada, si elle est peu instruite, si on lui a refusé la possibilité d'avoir un logement social, si elle souffre de problèmes de santé mentale, si elle a de la difficulté à se loger, si elle a recours fréquemment aux banques alimentaires et si elle est engagée dans le commerce du sexe (Dappleton Research Team, 2003).

Itinérance et santé

Comme la section précédente l'a montré, la représentation des Autochtones dans la population itinérante est disproportionnée et ils présentent plus de risques de devenir des sans-abri. Il est important d'en considérer les répercussions sur la santé des Autochtones au Canada, car la

littérature a démontré que les sans-abri ont des taux de morbidité et de mortalité supérieurs à la moyenne, et qu'ils doivent surmonter plus d'obstacles pour avoir accès à des services de soins de santé sûrs et efficaces. En fait, on a noté que les sans-abri présentent un risque inacceptablement élevé de nombreuses maladies évitables, de complications inutiles et de décès prématuré (Plumb, 2000). La relation entre l'itinérance et la santé est examinée plus en détail ci-après.

Les risques associés à l'itinérance, comme l'exposition aux éléments, une mauvaise nutrition, le manque de soutien, le manque d'accès aux services de santé, la stigmatisation, peuvent influencer négativement sur la santé et le bien-être des personnes et des familles vivant dans la rue. En fait, les sans-abri sont plus susceptibles de souffrir d'affections chroniques et médicales graves que la population en général (Hwang et Bugeja, 2000). Les affections chez les sans-abri sont souvent chroniques parce que l'accès au traitement et le traitement sont limités ou sporadiques. La gravité des maladies est également accrue par les conditions de vie et les circonstances associées à l'itinérance (Hwang, 2001). Les problèmes de santé cités le plus souvent chez les sans-abri sont la crise d'épilepsie, la bronchopneumopathie chronique obstructive et les affections squeletto-musculaires (Hwang, 2001). Les statistiques tirées du *Street Health Research Bulletin #3: Aboriginal People and Homelessness* de 2007, qui comparant la prévalence de plusieurs maladies chroniques dans la population des sans-abri autochtones et la population en général, présentent les risques élevés de développer des affections chroniques auxquels sont exposés les sans-abri autochtones.

Tableau 1. Prévalence des maladies chroniques dans la population autochtone par rapport à la population en général

Maladie	Autochtones sans abri	Population générale*
Arthrite ou rhumatisme	43%	14%
Maladie cardiaque	35%	4%
Bronchopneumopathie chronique obstructive	24%	1%
Asthme	22%	6%
Diabète	22%	4%

Source : (Street Health, sous presse)

Note : les données sur la population en général sont tirées de l'Enquête sur la santé dans les collectivités canadiennes (ESCC), cycle 3.1 (2005). Cette analyse se fonde sur l'ESCC, cycle 3.1 (2005), fichier de microdonnées à grande diffusion, qui contient des données anonymes. Street Health a préparé tous les calculs sur ces microdonnées et l'utilisation et l'interprétation de ces données sont l'entière responsabilité de l'auteur.

En plus d'être reliée à ces maladies chroniques plus courantes, l'itinérance est souvent associée au développement et à la persistance de problèmes de santé mentale. Bien que ces problèmes ne soient pas toujours abordés ou mesurés en fonction de leur caractère chronique ou persistant, il est important de les mentionner ici. La recherche sur les populations non autochtones démontre que les personnes souffrant d'une maladie mentale chronique présentent plus de risques de devenir des sans-abri que les autres (Folsom et coll., 2005). Le tableau suivant démontre la

prévalence élevée de certains problèmes de santé mentale courants chez les sans-abri autochtones.

Tableau 2. Problèmes de santé mentale les plus courants signalés par les sans-abri autochtones

Problèmes de santé mentale	%
Anxiété	11 %
Dépendance aux drogues et à l'alcool	11 %
Bipolarité (maniacodépression)	7 %
Syndrome de stress post-traumatique	6 %
Trouble panique	6 %
Schizophrénie	0 %

Source : Street Health, sous presse

Malgré l'exactitude de ces données et la corrélation entre les problèmes de santé mentale chez les Autochtones et les non-autochtones, certaines différences entre les deux groupes indiquent qu'il y a place à la recherche dans ce domaine. Par exemple, les anciens combattants amérindiens sans-abri vivent moins de problèmes psychiatriques et beaucoup plus de problèmes d'alcoolisme que les anciens combattants sans-abri non amérindiens (Kaspro et Rosenheck, 1998). Dans l'ensemble, les Autochtones sans-abri présentent malheureusement des niveaux alarmants d'isolement social et un manque flagrant de soutien social. Les drogues et l'alcool sont souvent consommés pour aider à faire face à la maladie, au traumatisme, à la douleur et pour soulager l'isolement. Étant donné les dures réalités quotidiennes des sans-abri et l'héritage de violence et d'exclusion historique partagé par beaucoup trop d'Autochtones canadiens, les niveaux élevés d'abus d'intoxicants et d'automédication signalés par les sans-abri autochtones ne sont tristement pas étonnants. Tel que Street Health (sous presse) l'indique, les sans-abri autochtones présentent de hauts niveaux d'abus d'intoxicants. Par exemple, le sondage de 2007 indique que 92 % fument des cigarettes et 89 % d'entre eux fument tous les jours, 77 % avaient régulièrement consommé des drogues illicites autres que la marijuana au cours de l'année précédente, 26 % s'étaient injecté des drogues au cours de l'année précédente, 29 % avaient bu cinq consommations ou plus en une occasion au moins une fois par semaine au cours de l'année précédente, et 15 % avaient consommé de l'alcool non destiné à servir de boisson au cours de l'année précédente.⁵

En plus d'avoir une prévalence élevée, les maladies chroniques, physiques et mentales, chez les sans-abri autochtones ne sont pas toujours diagnostiquées et sont souvent mal contrôlées. Ces deux situations peuvent conduire au décès prématuré et à une morbidité excessive (Hwang, 2001; Hwang et Bugeja, 2000). Par exemple, des diabétiques ont indiqué éprouver plus de difficultés à gérer leur régime alimentaire et avoir des problèmes logistiques associés à leurs soins personnels (Hwang et Bugeja, 2000; Plumb, 2000). En outre, en Colombie-Britannique, les sans-abri autochtones présentent un taux de mortalité 2,1 fois plus élevé que celui du reste de la province (Helin, 2002). Le recours au système de soins de santé par les sans-abri laisse aussi transparaître

⁵ L'alcool non destiné à servir de boisson est de l'alcool présenté sous une forme qui n'est pas destinée à la consommation. Il comprend des produits comme le rince-bouche, le gel pour les mains, le vin de cuisson et l'alcool à friction.

certains problèmes de santé. Les sans-abri sont admis à l'hôpital cinq fois plus souvent que la population en général, généralement par la salle d'urgence, et sont hospitalisés plus souvent que les autres patients à faible revenu (Hwang, 2001). Non seulement ces séjours fréquents et prolongés à l'hôpital engendrent des coûts élevés pour les soins de santé, mais ils constituent des soins disparates à court terme qui ne favorisent pas un traitement préventif et complet.

Logement insalubre

Les mauvaises conditions de logement, un logement surpeuplé et inadéquat, et l'absence de propriété prévalent dans de nombreuses communautés autochtones. Pour ces raisons et d'autres, le logement dans les communautés autochtones est souvent sous la norme. Un examen de ces problèmes de logement et de leur impact sur la santé est présenté ci-après pour mieux comprendre le lien entre le logement et la santé des Autochtones au Canada.

Dans les communautés des Premières nations, le type de logement varie, mais généralement le logement dans les réserves est vieux et nécessite des rénovations et un meilleur entretien. Selon l'enquête régionale sur la santé de 2002-2003, le tiers (33,6 %) des maisons des Premières nations nécessitent des réparations majeures et un autre tiers (31,7 %), des réparations mineures. Alors que chez les ménages dont le revenu est inférieur à 20 000 \$, le logement est plus susceptible de nécessiter des réparations et un entretien plus régulier, les taux varient selon la tranche de revenu, mais ils demeurent très élevés (26,4 %) pour les tranches de revenu plus modestes (50 000-79 999 \$) (Centre des Premières Nations, 2005). Ces chiffres indiquent des problèmes systémiques et sous-jacents en matière de logement dans tous les secteurs de la société autochtone. Les statistiques documentant le nombre de logements nécessitant des réparations ont augmenté considérablement depuis celles du groupe de travail Neilson de 1985 (Centre des Premières Nations, 2005), ce qui est préoccupant pour l'avenir; ainsi, le progrès est lent quant aux améliorations notées par les participants à l'enquête régionale sur la santé de 2002-2003 (Centre des Premières Nations, 2005). En plus des problèmes touchant la construction et l'entretien, il faut également compter avec ceux qui concernent l'offre de logements. En 2001, Affaires indiennes et du Nord Canada (AINC) indiquait une pénurie de 8 500 logements dans les réserves (Gouvernement du Canada, 2003). Toutefois, l'Assemblée des Premières nations estime qu'il manque 80 000 logements (Centre des Premières Nations, 2005). Cette situation du logement pourrait éventuellement avoir un impact sur la santé puisqu'elle réunit les conditions nécessaires pour la croissance des moisissures, la détérioration de la qualité de l'air intérieur et une piètre ventilation. On ne sera pas surpris d'apprendre que ces problèmes tendent à affecter le système respiratoire, à réduire la fonction pulmonaire et la croissance, et peuvent mener à des problèmes respiratoires chroniques (Anto et coll., 2001; Cardinal, 2004).

La moisissure peut exister et croître dans la structure de la maison. On a constaté que la moisissure peut causer des allergies, l'asthme, l'irritation des yeux et de la gorge, des otites moyennes et des affections des voies respiratoires inférieures (Daigler, Markello et Cummings, 1991; Centre des Premières Nations, 2005; O'Neil, 2000), mais on ne peut pas dire clairement comment ces interactions se produisent et s'il y a une relation directe entre la moisissure et des affections respiratoires particulières (Centre des Premières Nations, 2005). Toutefois, on a conclu que des recherches supplémentaires sur les problèmes de moisissure ne présentaient pas un potentiel suffisant pour améliorer les problèmes de santé aigus et chroniques dans les communautés où il y a prévalence de moisissure (O'Neil, 2001). Comme la moisissure a besoin

d'humidité pour croître et qu'environ la moitié des maisons des Premières nations ont besoin de réparations, la probabilité d'une importante prévalence de la moisissure dans les maisons autochtones est très forte. En outre, moins il y a de ventilation, plus la possibilité de moisissure augmente. Bien qu'il y ait des mesures pour assurer l'évacuation des maisons où le développement de la moisissure est important ou présentant des niveaux de contamination qui dépassent les normes, ces mesures et ces contrôles n'existent pas dans les réserves. Cela est dû en grande partie au fait qu'il y a peu d'autorités sanitaires dans les communautés des Premières nations qui ont les compétences requises et qu'il manque de logements pour accueillir les personnes vivant dans un logement insalubre (Centre des Premières Nations, 2005).

Les problèmes associés à la moisissure et à la ventilation affectent la qualité de l'air des maisons. Alors que la qualité de l'air extérieur a retenu l'attention des médias au cours des deux dernières décennies (voir la section 2.2.4), les effets néfastes de la pollution de l'air intérieur sont souvent négligés. Cette pollution est courante dans les communautés autochtones où des poêles à bois et au charbon sont encore en usage, où le tabac est utilisé pour les cérémonies et les réunions, et où la moisissure et une mauvaise ventilation prévalent. Ces facteurs sont préoccupants pour la santé et le bien-être des Autochtones dans leur maison. À partir de données probantes sur l'exposition à la fumée du tabac à la maison et au travail, Greer (Greer, Abbey et Burchette, 1993) a démontré que les environnements intérieurs ont un effet plus important sur le développement de problèmes respiratoires que les polluants atmosphériques extérieurs. La recherche a démontré que, en plus de la fumée du tabac, la qualité de l'air intérieur peut accroître la prévalence des allergies et de l'asthme (Institut canadien d'information sur la santé, Santé Canada et Statistique Canada, 2001). La prévalence et l'incidence de la tuberculose et d'autres affections respiratoires ont été associées à la qualité de l'air intérieur. Puisque la fumée du tabac et la moisissure sont les seuls facteurs intérieurs consistants associés aux affections chroniques, la recherche sur les effets de la pollution de l'air intérieur et ses divers éléments devrait être accentuée et obtenir plus d'attention du milieu de la recherche.

Il est justifié de s'intéresser aux effets potentiels que la pollution de l'air intérieur aura sur la santé dans l'avenir si l'on se fie aux études montrant que les Autochtones passent plus de temps à l'intérieur (Centre des Premières Nations, 2005). L'impact particulier que la pollution de l'air intérieur a sur certains des sous-ensembles les plus vulnérables de la population autochtone, comme les aînés, les jeunes enfants et les malades chroniques (qui tendent à passer encore plus de temps à l'intérieur que le sujet moyen) sera également important à considérer.

En conclusion de cette discussion sur la qualité de l'air, il est important de noter que la qualité de l'air intérieur et la qualité de l'air extérieur (voir la section 2.2.4 ci-dessous) sont souvent abordées séparément. Bien que la distinction soit importante à faire, il est également important de reconnaître le lien entre les deux : « la maison moyenne offre peu de protection contre les aérosols, les particules et la contamination par les gaz dans l'air en général » (Centre des Premières Nations, 2005); un logement insalubre en offre encore moins. Même si certaines communautés autochtones ont exprimé des inquiétudes quant à la qualité de l'air extérieur parce qu'elles sont situées près de sites industriels, le fait que de nombreuses réserves sont situées en milieu rural et éloigné signifie que les préoccupations associées au smog sont probablement moins importantes. Toutefois, cela signifie que la contamination de la maison peut être une plus grande préoccupation pour les communautés, les familles et les personnes autochtones (Centre des Premières Nations, 2005).

En plus de l'impact sur la santé des problèmes liés à la qualité de l'air découlant de la mauvaise ventilation, des polluants intérieurs et des particules extérieures, on a constaté que le surpeuplement peut affecter le système respiratoire, favoriser la transmission des maladies respiratoires et favoriser le développement d'affections chroniques. Malheureusement, des problèmes de densité d'occupation (surpeuplement) ont été signalés dans les communautés autochtones (Centre des Premières Nations, 2005). En général, une maison est considérée comme surpeuplée si la densité dépasse une personne par pièce. La densité globale au Canada, selon le recensement de 2001, est de 0,4 personne par pièce (Santé Canada, 2002), alors que l'enquête régionale sur la santé indique une densité moyenne de 0,76 (Centre des Premières Nations, 2005). Cela se traduit par une moyenne d'environ 2,6 personnes par maison dans la population en général et de 4,8 personnes par maison chez les Autochtones (Centre des Premières Nations, 2005). Dans certains cas, l'occupation dans les communautés autochtones est très élevée; le nombre le plus élevé de personnes par maison signalé par l'enquête régionale sur la santé était de 18 (Centre des Premières Nations, 2005). Bien que les statistiques varient quant à la proportion de maisons autochtones surpeuplées (de 12 % à 17,2 %) (Centre des Premières Nations, 2005; Affaires indiennes et du Nord Canada, 2005), il est certain que les maisons des communautés autochtones comptent plus de personnes par pièce que celles de la population canadienne (Centre des Premières Nations, 2005; Santé Canada, 2002). La recherche ayant également démontré qu'une grande proportion de surpeuplement influe sur la santé et le bien-être de la personne et de la communauté, le surpeuplement des maisons pose un important problème. Par exemple, il est documenté et reconnu que le surpeuplement pendant la nuit est un important facteur de risque d'infections des voies respiratoires supérieures et inférieures dans une population inuite du Groenland (Koch et coll., 2003); d'autres études dans les communautés autochtones ont également démontré que le surpeuplement et la détresse respiratoire sont associés (Fraser-Lee et Hessel, 1994). Les statistiques de l'enquête régionale sur la santé de 2002-2003 indiquent qu'un répondant sur trois ayant eu un diagnostic de tuberculose vit dans une maison surpeuplée. Il est également important de se préoccuper des impacts à long terme du surpeuplement sur la santé étant donné que l'enquête régionale sur la santé de 2002-2003 indique que 24,6 % des maisons avec enfants étaient surpeuplées (Centre des Premières Nations, 2005).

Les modes de propriété et de location sont également des facteurs importants à considérer lorsqu'on examine les conditions de logement des Autochtones au Canada. Les différences entre le logement autochtone et non autochtone sont claires si l'on compare la propriété, la location et le logement social. On a constaté que, dans la population en général, 65 % des familles possèdent leur maison, la plupart des autres sont à loyer et peu de gens dépendent du logement social (Statistique Canada, 2001). Dans la population autochtone, la situation est inversée : « 61,9 % des familles des réserves vivent dans un logement appartenant à la bande, ce qui correspond au logement social » (Centre des Premières Nations, 2005). Comparativement, 74,1 % des Autochtones habitant dans les provinces avec un revenu de moins de 10 000 \$ et 64,4 % avec un revenu de moins de 30 000 \$ vivent dans un logement social. Les ménages ayant un revenu de 30 000 à 80 000 \$ vivent également dans une maison appartenant à la bande (Centre des Premières Nations, 2005). Le taux élevé d'occupation d'une maison appartenant à la bande est le résultat de la pauvreté, les banques n'accordant pas d'hypothèque aux résidents des réserves, et de certains problèmes de nature géographique qui entravent l'accès à la construction. Un problème de santé lié au logement appartenant à la bande dans les communautés des Premières nations est le haut pourcentage de moisissure et de mildiou déclaré (48,7 %). La déclaration de 36,9 % dans d'autres Premières nations est également préoccupante (Centre des Premières

Nations, 2005). Parce que la population urbaine tend à être davantage composée de locataires que la population en général, il y a également des problèmes en ce qui a trait à la moisissure, à la mauvaise qualité de l'air et aux défauts de structure non réparés (Beavis et coll., 1997). Ainsi, la mauvaise qualité de l'air et la moisissure sont également de réelles préoccupations dans ces circonstances.

Le lien étroit entre l'environnement et la situation socio-économique réaffirme la nécessité d'aborder les questions socioculturelles de façon plus large et de tenir compte des changements de la qualité de l'air avec le temps. Tant que des données probantes font état d'une mauvaise qualité de l'air, de mauvaises conditions de logement, de pollution de l'air intérieur, de surpeuplement et de pauvreté dans les communautés autochtones, une recherche ciblée doit rapidement être entreprise pour examiner l'impact de ces facteurs sur la santé des Autochtones et leur relation avec les maladies respiratoires chroniques.

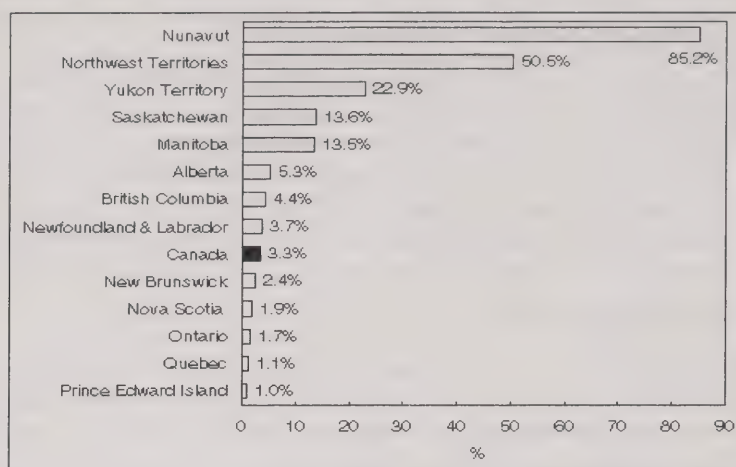
2.2 Facteurs de risque géographiques

En plus du statut économique et des conditions de logement des Autochtones, l'emplacement géographique peut exacerber les problèmes de santé et de bien-être en réduisant l'accès aux installations, aux fournitures et aux services de soutien. La qualité et la nature du territoire peuvent également déterminer la santé d'une population. Il est question de ces aspects ci-après.

2.2.1 Emplacement de la communauté

L'emplacement géographique peut être un important indicateur de la santé et du bien-être d'une communauté. Afin d'étudier la relation entre l'emplacement et la santé, les régions sont souvent classées selon la densité de leur population, leur proximité avec un centre urbain, des commodités ou d'autres communautés et l'accessibilité de la communauté. L'emplacement et l'accessibilité peuvent être classés dans les catégories suivantes : grande ville, milieu urbain, banlieue, milieu rural, éloigné et isolé. Bien que ces termes n'aient aucune définition standardisée, la plupart des définitions sont basées sur des questions d'accessibilité comme la distance des grands centres urbains, l'accès routier ou aérien, et l'accès au téléphone ou à Internet. Des notions de direction sont également utilisées : surtout nord et sud pour marquer les différences de densité et d'accessibilité, et les termes peuvent être combinés (p. ex. nordique-isolé). On peut voir dans la figure suivante que la population autochtone du Canada est répartie dans chaque province et territoire, et qu'elle constitue la majorité de la population du Nunavut et des Territoires du Nord-Ouest ainsi qu'une partie importante de la population des provinces des Prairies.

Figure 3. Population déclarant une identité autochtone selon son pourcentage de la population totale, Canada, provinces et territoires, 2001



Source : Canada, 2001

Bien que cette figure soit quelque peu trompeuse – elle ne présente pas les effectifs de la population –, elle démontre cependant l'importance du Nord pour de nombreux Autochtones et la proportion supérieure d'Autochtones dans les provinces plus traditionnelles et rurales de la Saskatchewan, du Manitoba et de l'Alberta. Le terme « rural » est souvent utilisé pour parler d'une communauté ou d'une résidence personnelle qui est loin d'un grand centre urbain, des commodités ou d'autres communautés. Le terme « éloigné » est souvent utilisé pour parler de communautés et de localités qui ne sont accessibles qu'en certaines saisons (p. ex. route de glace), ou encore qu'on en peut atteindre que par avion ou par une route de gravier ou mal entretenue. Comme c'est une réalité pour de nombreux Autochtones au Canada, il est important d'examiner les impacts de cette situation sur la santé.

Quelle que soit l'ethnicité, on a constaté que le milieu rural est associé à une mauvaise nutrition, à l'inactivité et à des taux de tabagisme élevés (ICIS, 2006). Ces facteurs de risque sont généralement supérieurs dans la population rurale moyenne que dans la population urbaine (ICIS, 2006). La résidence rurale, particulièrement si elle s'accompagne de facteurs de risque socio-économiques, peut également diminuer l'accès aux soins de santé (voir la section 2.2.2 pour plus de détails). Malgré ces statistiques négatives, des points de vue divergents persistent, car il a été démontré que la résidence rurale ou éloignée est bénéfique pour la santé et le bien-être des Autochtones au Canada. C'est particulièrement vrai lorsque la vie rurale équivaut à la vie nordique. Des études ont démontré que les Autochtones du Nord rapportent moins de maladies chroniques que les autres résidents du territoire (Tjepkema, 2002). En outre, la population autochtone hors réserve vivant dans les territoires présente une prévalence inférieure de maladies chroniques que la population provinciale (Tjepkema, 2002). Ce modèle semble indiquer que les Autochtones vivant dans le Nord n'ont peut-être pas été exposés aux mêmes changements du mode de vie ou ne les ont pas expérimentés avec la même intensité que les communautés autochtones du Sud (Tjepkema, 2002). Les divergences entre les données peuvent être

expliquées par le fait que des compromis existent entre l'accessibilité d'une communauté et son isolement, notamment les impacts négatifs potentiels de la colonisation par rapport à l'accès aux commodités et aux possibilités d'emploi. Les influences conflictuelles pourraient comprendre les avantages positifs des communautés plus isolées et autosuffisantes par rapport à l'isolement de la communauté des influences extérieures.

En plus de vivre dans des environnements différents de ceux des communautés urbaines ou suburbaines, les Autochtones des communautés rurales et nordiques expérimentent la différence de la vie en réserve et hors réserve. À cause de la migration croissante des Autochtones vers les villes, environ 30 % de la population autochtone du Canada vit dans les réserves (CBC, 2003). Il a été démontré que les réserves ont un impact particulier sur la santé. Malgré les grands avantages liés au développement communautaire et social qu'une réserve peut offrir, les réserves demeurent en grande partie régies et contrôlées par le gouvernement canadien. Il a été démontré qu'il existe une relation entre la gouvernance et la santé, l'autonomie gouvernementale soutenant des environnements sains et le manque d'autonomie ayant été associé à des comportements et à des environnements malsains (Chandler et Lalonde, 1998).

Comme cette brève discussion le démontre, les Autochtones vivant dans une réserve, dans les territoires du Nord ou dans d'autres régions éloignées du pays, sont exposés à des facteurs de risque complexes associés à leur emplacement géographique. Dans les réserves et en milieu rural ou nordique, l'accès aux services pose un important problème. La littérature examinant l'impact des problèmes d'accès est présentée plus en détail ci-après.

2.2.2 Accès à des soins de santé de qualité

Tel qu'indiqué dans les deux sous-sections précédentes, l'accès d'une communauté aux soins de santé et à d'autres services de santé est une dimension importante de son profil de santé. Dans ce cas, l'accès à des soins de santé de qualité renvoie à la disponibilité des soins de santé primaires « occidentaux ». Bien que l'accès au système biomédical occidental soit important, il faut se rappeler que certains Autochtones peuvent utiliser ces services parallèlement aux pratiques de santé traditionnelles, dans un contexte spécial ou pour des raisons particulières (Centre des Premières Nations, 2005). Les problèmes d'accès sont importants lorsqu'on examine la santé des populations. En effet, la littérature indique que les pays ayant un meilleur accès aux soins de santé primaires sont moins susceptibles de déclarer des disparités en matière de santé (Mackinko, Starfield et Shi, 2003). Par ailleurs, la recherche montre qu'un accès insuffisant aux soins de santé et aux services peut contribuer à des taux de survie inférieurs et à des taux de mortalité supérieurs dans certaines populations. Considérant que la population autochtone du Canada a vécu de graves inéquités en matière de santé comparativement à la population non autochtone, l'accès aux services et aux soins est un important déterminant de la santé à étudier dans cette population.

L'enquête régionale sur la santé de 2002-2003 présente de l'information sur l'accès aux soins de santé. Par exemple, on a demandé aux participants à l'enquête d'évaluer leur santé et leur accès aux soins de santé. Voici la relation entre ces deux facteurs :

« Les répondants autochtones qui évaluent leur santé comme étant très bonne ou excellente estiment leur accès aux services de santé comme étant meilleur (24,6 %) ou identique (45,5 %) à celui des Canadiens. Ceux qui estiment avoir une santé passable ou

mauvaise ont été moins enclins à déclarer avoir le même niveau d'accès que ceux qui qualifient leur santé de bonne, très bonne ou excellente. » (Centre des Premières Nations, 2005)

Les différences ne semblent pas importantes entre les sexes et les différents groupes d'âge. Toutefois, les répondants plus instruits étaient plus susceptibles d'évaluer que leur accès aux services était inférieur à celui de la population canadienne en général (Centre des Premières Nations, 2005).

Les données de l'Enquête sur la santé dans les collectivités canadiennes (ESCC) et l'Enquête auprès des peuples autochtones présentent également des données intéressantes sur l'accès aux soins de santé des populations hors réserve et dans les réserves du Canada. Par exemple, les données des enquêtes de 2000-2001 indiquent les taux de contact avec des généralistes de la population autochtone hors réserve, comme le rapporte la citation suivante :

« 78,8 % des Autochtones hors réserve ont déclaré avoir vu un généraliste au moins une fois au cours des 12 mois précédents, une proportion très différente de celle de la population non autochtone. Toutefois, les Autochtones vivant dans les territoires étaient beaucoup moins susceptibles d'avoir vu un généraliste que les autres résidents du Nord (58,8 % par rapport à 75,9 %). » (Tjepkema, 2002)

Les faibles taux de consultation d'un médecin par les Autochtones du Nord sont plus évidents quand on les compare à ceux des non-autochtones du Nord : 31,1 % des Autochtones ont un médecin régulier par rapport à 67,0 % des résidents non autochtones. Bien que moins d'Autochtones vivant dans les provinces déclarent avoir un médecin régulier, la différence entre la population autochtone et la population non autochtone dans les provinces est moindre (Tjepkema, 2002). Fait intéressant, « le contact avec les infirmières était quelque peu supérieur pour les Autochtones vivant dans les provinces, et de beaucoup supérieur pour ceux vivant dans les territoires » (Tjepkema, 2002). C'est probablement le résultat d'un modèle communautaire plus petit, où les centres de santé comptent principalement des infirmières à la direction et comme employées. Si l'on tient compte de ces différences et de ces disparités, il n'est pas surprenant que Tjepkema (2002) ait constaté que la population autochtone hors réserve indique plus de besoins de santé insatisfaits que la population non autochtone. Des résultats semblables ont été constatés pour la population des réserves. L'Enquête sur la santé des peuples autochtones de 2001 a révélé que les Autochtones des réserves étaient « moins susceptibles d'avoir vu un médecin » ou un autre professionnel de la santé (68 %) au cours de l'année précédente (61 %) que la population urbaine (73 % et 77 % respectivement). De plus, une étude a montré que la proportion d'Inuits qui avaient vu un médecin (47 %) ou un autre professionnel de la santé au cours de l'année précédente était la plus basse de tout le Canada (Newbold, 1998).

On a identifié plusieurs obstacles à l'accessibilité des services de santé pour la population autochtone du Canada. Bien que certaines préoccupations varient selon l'emplacement d'une personne ou d'une communauté, les autres sont plus répandues. Dans les réserves et les régions nordiques et rurales, le manque de services locaux, le manque d'accès à un médecin ou à un autre professionnel de la santé, la nécessité de voyager pour avoir accès à un établissement de santé et obtenir un traitement médical sont souvent cités comme les principaux obstacles à des soins de santé adéquats (Centre des Premières Nations, 2005). Les préoccupations économiques associées au transport, à la garde des enfants et aux coûts directs de certains services de santé

sont encore plus répandues. Les obstacles culturels, comme le manque de soins adéquats sur le plan culturel et les problèmes d'accès aux soins traditionnels, sont également couramment mentionnés. Enfin, il existe des problèmes systémiques : se voir refuser l'approbation des services dans le cadre du système des Services de santé non assurés (SSNI) ou ne pas être couvert par les SSNI, et les longues listes d'attente continuent d'affliger de nombreuses familles et communautés autochtones (Centre des Premières Nations, 2005). Considérant que le but des SSNI est d'aider les Premières nations à atteindre un état de santé comparable à celui de la population du Canada en général, ces données suggèrent que le programme des SSNI agit comme un obstacle à l'accès aux soins.

La nécessité de services locaux et appropriés sur le plan culturel est importante dans le cadre d'une discussion sur les obstacles à l'accès aux services de santé par les Autochtones au Canada. L'importance de cet aspect est justifiée par des données probantes dans les rapports demandant un meilleur accès aux soins de santé pour les communautés ayant un accord de transfert en matière de santé⁶ (Centre des Premières Nations, 2005). La politique de transfert en matière de santé permet à la communauté de mieux contrôler les services et, ainsi, d'offrir localement des services plus pertinents sur le plan culturel. Fait intéressant, « les répondants des communautés ayant un accord de transfert dans le cadre d'un transfert pluricommunautaire sont plus susceptibles d'évaluer leur accès aux services de santé comme étant généralement inférieur à celui des Canadiens » (Centre des Premières Nations, 2005). Cette conclusion remet en question l'efficacité du système de transfert en matière de santé, indiquant que plus de recherche est nécessaire pour évaluer cette politique et ses répercussions sur l'accès aux soins de santé ainsi que sur l'état de santé et le bien-être général.

Services de diagnostic, de dépistage et de prévention

La disponibilité des services de diagnostic, de dépistage et de prévention est souvent considérée comme un indicateur de l'accès aux soins de santé et de leur rendement. C'est pourquoi il est question de la disponibilité de ces services ci-après.

Dans le domaine du cancer, on croit que les services de diagnostic et les interventions de dépistage et de prévention jouent un rôle important sur l'incidence, la mortalité et la survie. La participation de la population autochtone aux programmes de dépistage du cancer demeure plus faible que celle de la population en général, ce qui est préoccupant (Kue Young, Kliwer, Blansharg et Mayer, 2000). Le dépistage du cancer cervical chez les femmes autochtones par un test de PAP est traditionnellement faible (Clarke et coll., 1998). Toutefois, les données de l'enquête régionale sur la santé de 2002-2003 montrent que la couverture du test de PAP est relativement semblable entre les populations autochtones et non autochtones. Bien que ce soit une nette amélioration, les données de cette enquête indiquent qu'« étant donné le taux de mortalité disproportionné des femmes autochtones par cancer cervical, il serait à conseiller d'appliquer de façon plus systématique des programmes de dépistage propres aux Premières nations » (Centre des Premières Nations, 2005). D'autres données de la recherche indiquent qu'en plus des problèmes d'accès aux programmes de dépistage du cancer, le manque de

⁶ La politique de transfert en matière de santé a été adoptée officiellement par Santé Canada en 1989 et se poursuit de nos jours. Elle permet aux communautés autochtones de contrôler l'affectation des ressources à des programmes et services particuliers, offrant ainsi aux communautés la possibilité d'une plus grande autonomie et du contrôle des soins de santé.

connaissances des programmes et services disponibles contribue aux problèmes associés au dépistage du cancer (Condon, Barnes T., Armstrong B.K., Selva-Nayagam S. et J.M., 2005). Ainsi, l'éducation et la sensibilisation devraient être considérées comme faisant partie intégrante des stratégies visant à améliorer les programmes de dépistage. D'autres problèmes relatifs à la faible participation à certains tests de dépistage, comme le toucher rectal, nécessitent un examen plus approfondi (Centre des Premières Nations, 2005).

En plus du cancer, on croit que les lacunes et les délais quant au test de glycémie chez les Autochtones sont liés à l'augmentation du diabète de type 2 dans cette population. L'enquête régionale sur la santé de 2002-2003 indique que moins de 50 % des personnes des groupes d'âge à risque ont été dépistées pour le diabète dans les 12 derniers mois (Centre des Premières Nations, 2005). Étant donné les proportions épidémiques de diabète dans la population autochtone, ce pourcentage est beaucoup trop faible. Le dépistage des maladies cardiovasculaires par les tests de cholestérol et d'hypertension est également insuffisant : le test de cholestérol est faible pour tous les groupes d'âge, alors que le test d'hypertension est supérieur, mais n'atteint pas un taux idéal (Centre des Premières Nations, 2005).

2.2.3 Changements climatiques, qualité de l'air extérieur et contaminants dans l'environnement

L'importance de l'environnement sur la santé a retenu l'attention de façon importante au cours des dernières années grâce à la plus grande sensibilisation du public et au débat sur les questions entourant les changements climatiques. Comme les sociétés autochtones sont traditionnellement très attachées à la terre, les problèmes associés aux changements climatiques sont amplifiés dans le contexte autochtone (Paci, Dickson, Nickels, Furgal et 2004). L'emplacement de nombreuses communautés autochtones dans le Nord et dans les régions éloignées rend les impacts encore plus évidents. Le réchauffement planétaire et les changements environnementaux comme la fonte des glaces y sont beaucoup plus visibles que ce qu'on observe dans les régions du sud du Canada.

Les problèmes liés à la qualité de l'air extérieur ont été au centre des débats sur les changements climatiques et sur le lien entre l'environnement et la santé humaine. En réponse à une préoccupation croissante concernant les « nouveaux polluants »⁷ dans les années 1980, la recherche sur les conditions environnementales a porté sur l'association présumée entre une augmentation des particules dangereuses dans l'air et l'incidence des problèmes respiratoires (Strachan, 2000). Cette hypothèse a été corroborée par des études sur des cohortes de non-fumeurs (Abbey et coll., 1995; Greer et coll., 1993), qui ont conclu à des incidences significativement supérieures d'asthme et de symptômes respiratoires chroniques chez des personnes ayant d'importantes expositions cumulatives aux particules et à l'ozone. Les effets considérables des polluants extérieurs sur la santé humaine et leur potentiel comme facteur de risque de maladies respiratoires chroniques ne devraient toutefois pas éclipser le rôle que la pollution de l'air intérieur peut jouer dans la santé respiratoire d'une personne (Anto et coll., 2001).

⁷ L'expression « nouveaux polluants » se rapporte aux particules et aux gaz dangereux (gaz à effet de serre) provenant des émissions des véhicules, des procédés industriels et des pratiques commerciales.

La préoccupation environnementale associée aux contaminants et à l'impact des sous-produits industriels, des produits chimiques et d'autres particules sur la santé humaine est reliée à la discussion sur l'impact de la pollution atmosphérique. Une importante préoccupation des communautés autochtones et inuites est l'exposition aux biphényles polychlorés (BPC). On croit que les BPC sont responsables de l'incidence accrue du cancer et d'autres problèmes de santé. Les BPC s'accumulent dans les tissus par la chaîne alimentaire, et les Autochtones qui consomment du poisson dans leur régime alimentaire traditionnel ont une concentration très élevée de BPC dans leur gras corporel. On a observé que des femmes inuites du nord du Québec ont une concentration de BPC dans leur lait maternel sept fois plus élevée que les femmes canadiennes (MacMillan et coll., 1996). De plus, le lait de ces femmes autochtones contient la concentration de BPC la plus élevée au monde. En même temps, le gouvernement du Canada a indiqué que la concentration de BPC pouvant causer le cancer est beaucoup plus élevée que toute exposition environnementale possible (Santé Canada, 1994; Murray, 1994). Le mercure accumulé dans les tissus du poisson est une préoccupation pour de nombreuses communautés autochtones, particulièrement celles pour qui le poisson constitue la principale source d'alimentation (Van Oostdam et coll., 2005). Le mercure inorganique et méthylé a été désigné comme un cancérigène probable et on croit que sa présence à une concentration élevée augmente le risque de cancer. Selon une étude réalisée sur des Inuits vivant dans l'île de Baffin, l'absorption quotidienne de mercure était en moyenne de 65 mg chez les femmes et de 97 mg chez les hommes, ce qui dépasse largement l'absorption quotidienne moyenne de 16 mg des autres Canadiens (MacMillan et coll., 1996). Le mercure a été associé à d'autres problèmes de santé, comme les problèmes du système nerveux central et les difficultés d'apprentissage, et c'est une importante préoccupation quant à la santé et au bien-être des Autochtones.

Le principal défi posé par les contaminants environnementaux, c'est qu'ils se trouvent souvent dans les aliments « traditionnels », soit la catégorie générale utilisée pour décrire tous les nutriments organiques et animaux qui assurent la santé des Autochtones (Paci et coll., 2004). Au Canada, les aliments traditionnels courants sont le poisson, le gibier, les petits fruits et les autres légumes, fruits et grains récoltés. L'importance de la discussion sur la cueillette et la consommation, passées, actuelles et futures, des aliments traditionnels chez les Autochtones au Canada découle du fait qu'ils peuvent être des facteurs de protection pour plusieurs maladies chroniques. La corrélation entre la consommation d'aliments traditionnels et une meilleure santé résulte également de la meilleure valeur nutritive de ces aliments et de l'exercice associé à la chasse et à la cueillette nécessaires pour les obtenir. La consommation d'aliments traditionnels est également bénéfique pour réduire la présence accrue des « aliments modernes » (aliments préparés, prêt-à-manger, sucres simples, etc.) dans le régime alimentaire autochtone. Bien que ces aliments modernes ou occidentaux aient été introduits dans les communautés autochtones à différents moments et à diverses intensités (Paci et coll., 2004), leur présence est maintenant courante et répandue. En plus de favoriser la réduction des aliments traditionnels dans le régime alimentaire autochtone, ces aliments à bas prix et faciles à préparer sont malsains en soi : les croustilles et autres aliments à « calories vides » n'offrent pas aux enfants, aux parents et aux grands-parents les éléments nutritifs, les vitamines et les minéraux dont ils ont besoin pour survivre et se développer.

Le problème, c'est que les risques associés aux aliments traditionnels doivent être équilibrés avec ceux des aliments achetés à l'épicerie. De toute évidence, la sécurité alimentaire est une question importante, car les bons aliments sont essentiels à un développement optimal, particulièrement

pour les nourrissons et les jeunes enfants. Les émissions de gaz à effet de serre et l'empreinte de carbone de la société sur la santé de l'environnement ainsi que les préoccupations concernant le coût du carburant et la logistique du transport des aliments dans les communautés rurales et éloignées, comme de nombreuses réserves et communautés métisses, inuites et des Premières nations, sont des raisons d'encourager la consommation d'aliments traditionnels. Il est impératif que nous trouvions des moyens plus novateurs d'assurer l'équilibre entre la disponibilité, la diversité et la qualité des aliments pour tous les citoyens, autochtones et non autochtones, au Canada.

Enfin, car ce n'est là qu'un aperçu, l'information sur le rôle croissant des facteurs de risque environnementaux et leur relation avec une augmentation des maladies chroniques dans de nombreuses communautés autochtones mérite qu'on y consacre plus d'efforts de recherche (Lawrence et Martin, 2001).

3. Facteurs de risque prénataux

Dans le présent document, nous utilisons l'expression « facteurs de risque prénataux » pour désigner les facteurs qui se manifestent, qui existent ou qui influent sur l'être humain avant sa naissance. Ces facteurs sont par conséquent liés à la santé de la mère et à celle de l'enfant à naître. La section qui suit portera donc sur le diabète maternel, l'obésité maternelle, ainsi que sur l'usage du tabac et la consommation d'alcool chez la mère. Par ailleurs, même si le poids à la naissance est souvent un indicateur de la présence d'effets intra-utérins, ce facteur sera examiné en détail dans la section suivante sur les facteurs de risque à la naissance, puisqu'il est évalué à la naissance et qu'il influe sur la santé du nouveau-né et sur le risque de maladies chroniques.

3.1 Diabète maternel

Chez les Premières nations, les femmes représentent à peu près les deux tiers des cas de diabète diagnostiqués (Bobet, 1997), alors que c'est l'inverse dans l'ensemble de la population canadienne (Santé Canada, 1999). Non seulement les femmes autochtones enregistrent une prévalence généralement plus élevée de diabète de type 2 (Centre des Premières Nations, 2005), mais bon nombre d'entre elles souffrent aussi de diabète gestationnel (Mohamed et Dooley, 1998), un type de diabète que l'on définit par toute intolérance au glucose survenue ou détectée pour la première fois pendant la grossesse (Matthews, 2003). La présente section a pour objet d'examiner l'impact de ces taux élevés de diabète gestationnel sur les fœtus, et par conséquent, sur les générations futures.

Les recherches démontrent que le diabète maternel constitue un facteur prédictif important d'un poids élevé à la naissance (Dyck, Klomp et Tan, 2001; Godwin et coll., 1999; Harris et coll., 1997; Rodrigues et coll., 1999). Comme les impacts directs du poids élevé à la naissance sont examinés plus loin (voir la section 4 sur les facteurs de risque à la naissance), nous traiterons dans cette section-ci de la corrélation entre le diabète gestationnel et la santé à long terme du fœtus. En examinant les recherches, on constate qu'en plus de présenter des taux élevés de macrosomie (poids élevé à la naissance > 4 000 g), les enfants dont les mères souffrent de diabète gestationnel sont aussi plus susceptibles de présenter des taux plus élevés d'obésité infantile et de souffrir d'intolérance au glucose ou de diabète de type 2 (Pettitt et Knowler, 1998; Silverman, Rizzo, Cho et Metzger, 1998). Une étude menée auprès des Pimas a aussi révélé une corrélation significative entre l'intolérance au glucose chez la mère et un plus grand risque de

diabète chez les enfants (Franks et coll., 2006). Étant donné qu'il y a aussi corrélation entre le diabète maternel et le poids élevé à la naissance, il faut donc se demander lequel de ces deux facteurs augmente les risques posés à la santé des enfants autochtones. Toutefois, une autre étude menée auprès des Pimas, qui a examiné des enfants de mêmes familles nés avant et après que leur mère eut reçu un diagnostic de diabète, a démontré que les enfants exposés au diabète *in utero* avaient un indice de masse corporelle (IMC) plus élevé que leurs frères et sœurs n'y ayant pas été exposés, et que leur risque de souffrir du diabète était près de quatre fois plus élevé (Dabelea et coll., 2000). Dans une autre étude, on a aussi estimé qu'environ 40 % des cas de diabète de type 2 chez les enfants pimas de 5 à 19 ans peuvent être attribués au diabète maternel pendant la grossesse (Dabelea et Pettitt, 2001). Ces données sur le diabète maternel montrent bien l'impact important que peut avoir l'environnement fœtal sur la santé future de l'enfant.

3.2 Obésité maternelle

Selon certaines études, l'obésité maternelle, qui est souvent associée au diabète gestationnel, pourrait être le principal facteur influant sur l'obésité juvénile (Boney, Verma, Tucker et Vohr, 2005; Whitaker et coll., 1998). Une étude américaine menée auprès d'enfants de leur naissance jusqu'à ce qu'ils aient de 6 à 12 ans a révélé que le diabète gestationnel n'avait pas à lui seul un impact significatif sur l'augmentation du risque de syndrome métabolique⁸ chez les enfants, mais que les enfants de femmes obèses présentaient un risque deux fois plus élevé d'en souffrir (Boney et coll., 2005). Si les résultats de ces études pouvaient être étendus à la population autochtone du Canada, alors la grossesse et la période qui la précède pourraient être considérées comme une période de la vie où il serait extrêmement efficace de cibler l'obésité pour ainsi réduire le fardeau du diabète de type 2 durant toute la petite enfance et l'âge adulte. Dans l'ensemble, ces résultats démontrent aussi une forte corrélation entre la santé maternelle et celle de l'enfant à sa naissance et toute sa vie durant. Nous allons maintenant examiner ce que dit la littérature concernant l'impact qu'un autre comportement maternel, à savoir l'usage du tabac, peut avoir sur le développement du fœtus et le risque de maladies chroniques.

3.3 Usage du tabac chez la mère

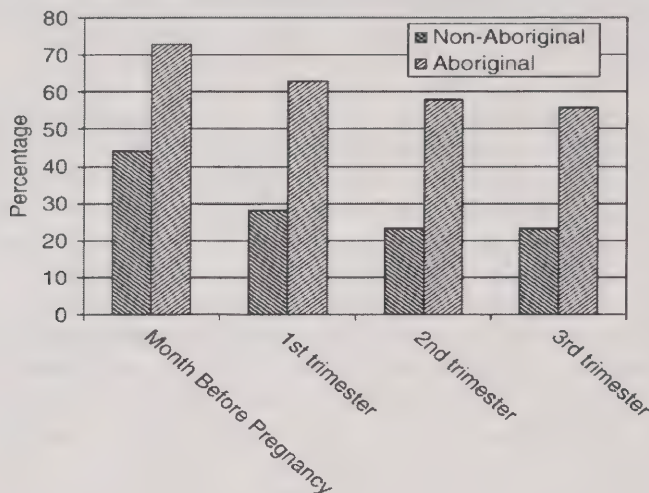
Une nette corrélation a été démontrée entre le tabagisme maternel et le retard de croissance intra-utérin au sein des populations autochtones et non autochtones. (Horta, Victora, Menezes, Halpern et Barros, 1997; Power et Jefferis, 2002; Wenman, Joffres et Tataryn, 2004). Toutefois, les proportions de femmes enceintes qui fument varient considérablement entre les divers groupes ethniques. Selon l'Enquête régionale longitudinale sur la santé des Premières Nations 2002-2003 (ERS), le taux de tabagisme chez les femmes autochtones enceintes (58,8 %) correspond à celui de la population autochtone en général. Une étude menée par le Manitoba auprès de 684 répondantes a révélé qu'une proportion nettement supérieure de femmes autochtones que de femmes non autochtones fumaient pendant leur grossesse (61,2 % contre 26,2 %), et qu'une plus faible proportion de femmes autochtones déclaraient cependant fumer plus d'un paquet de cigarettes par jour (Heaman, 2005). Ces résultats sont à l'opposé de ceux de l'ERS de 2002-2003, où le pourcentage de mères autochtones fumant plus de 10 cigarettes par jour était trois fois supérieur à celui de l'ensemble des mères canadiennes (5,3 % contre 15,0 %).

⁸ Le syndrome métabolique n'est pas une maladie en soi, mais plutôt un ensemble de troubles métaboliques dont souffre une personne (hypertension artérielle, taux d'insuline élevé, excès de poids, taux de cholestérol anormal, etc.) qui la rendent plus ou moins susceptible de souffrir de diabète, d'une maladie cardiaque ou d'un accident vasculaire cérébral.

Ces données signifient peut-être que le tabagisme modéré et constant est plus fréquent chez les mères autochtones, alors qu'on observe chez les mères non autochtones un plus faible nombre de fumeuses, mais qu'elles consomment davantage de cigarettes.

Le nombre moyen de cigarettes fumées par les femmes enceintes diminue par contre avec l'évolution de la grossesse, tant chez les populations autochtones que non autochtones. Cette diminution et les taux systématiquement plus élevés du tabagisme maternel au sein des populations autochtones sont illustrés dans la figure ci-dessous.

Figure 4. Prévalence du tabagisme selon les stades de la grossesse chez les femmes autochtones et non autochtones au Manitoba



Source : adaptation de Heaman (2005)

Traduction des termes du graphique :

Percentage = Pourcentage

Non-Aboriginal = Non-Autochtones - Aboriginal = Autochtones

Month Before Pregnancy = Mois précédant la grossesse

1st trimester = 1er trimestre, 2nd trimester = 2e trimestre, 3rd trimester = 3e trimestre

Comme l'explique Heaman (2005), un certain nombre de facteurs influent sur le tabagisme maternel. Son étude a notamment démontré qu'il y a une importante corrélation entre le tabagisme pendant la grossesse chez les mères autochtones à faible revenu et la consommation d'alcool pendant la grossesse, le manque de soutien, l'insuffisance des soins prénataux, des antécédents familiaux de fréquentation de pensionnats, le faible niveau d'instruction et le fait de vivre dans une communauté éloignée et isolée. Inversement, le fait d'avoir un emploi rémunéré et de vivre dans des communautés où de nombreux services de santé sont offerts réduit le risque de fumer pendant la grossesse (Heaman, 2005). En plus du tabagisme actif observé chez les mères dans les communautés autochtones, il importe aussi de tenir compte de leur exposition à la fumée secondaire. En effet, le tabagisme passif peut être considéré comme un aspect important puisque les statistiques démontrent que chez les Premières nations, il y a un usage du tabac dans les résidences de près d'une famille sur deux (48,2 %). Vu la prévalence généralement élevée de tabagisme actif et passif chez les mères des populations autochtones, il est important d'examiner

l'impact potentiel du tabagisme maternel sur les maladies observées plus tard dans la vie (Grove et coll., 2001; Reilly et coll., 2005; von Kries, Toschke, Koletzko et Slikker, 2002). Ce sujet sera d'ailleurs examiné plus loin.

Les effets néfastes du tabagisme maternel sur la croissance du fœtus ont souvent été observés. En effet, de nombreuses études ont démontré que l'usage du tabac pendant la grossesse retarde la croissance du fœtus (Cliver, 1995), ce qui peut entraîner un faible poids à la naissance (Humphrey, 2000; Mohsin, 2005) ou parfois des naissances prématurées (< 37 semaines), des mortinaissances et des morts néonatales (Chan, 2001; Kallen, 2001; Mohsin, 2005; Shah, 2000). L'ERS de 2002-2003 a établi une corrélation entre le faible poids à la naissance et une consommation excessive de tabac pendant la grossesse (lorsque les mères fument ≥ 20 cigarettes par jour). Le tabagisme a aussi été directement associé au syndrome métabolique et considéré comme un facteur préoccupant dans l'apparition de maladies respiratoires chroniques comme l'asthme chez les enfants (Daigler et coll., 1991). Cela s'explique par le fait que l'exposition du fœtus à la fumée peut affecter le développement du système pulmonaire *in utero* (Gilliland et coll., 2000; Hanrahan et coll., 1992). C'est pourquoi les risques d'infections respiratoires et d'asthme sont plus élevés chez les nourrissons de mères fumeuses que chez les nourrissons de mères qui ne fument pas (Gilliland et coll., 2000; Hanrahan et coll., 1992; Heaman, 2005). Des études ont aussi fait état des effets à long terme du tabagisme chez les mères autochtones. À cet égard, l'ERS de 2002-2003 précise que :

« les enfants qui ont été exposés à la fumée du tabac pendant la grossesse étaient moins souvent en "excellente" ou en "très bonne" santé, ils étaient plus susceptibles de souffrir de bronchites chroniques ou d'otites et un peu plus susceptibles de souffrir d'asthme ou d'allergies que les enfants n'y ayant pas été exposés. La distribution statistique selon les performances scolaires a indiqué une tendance vers des performances généralement moins bonnes chez les enfants dont la mère fumait pendant la grossesse » [traduction] (Centre des Premières Nations, 2005).

Ces tendances à long terme s'avèrent particulièrement préoccupantes pour la santé et le bien-être futurs des Autochtones.

3.4 Consommation d'alcool par la mère

L'alcool peut avoir des effets toxiques sur le fœtus connus comme les effets de l'alcool sur le fœtus (EAF) ou le syndrome d'alcoolisation fœtale (SAF), selon la quantité d'alcool consommée pendant la grossesse. Même si ces données ne font pas l'objet d'un consensus chez les scientifiques, Santé Canada indique qu'une consommation régulière de deux verres ou plus par jour est nocive pour le fœtus et qu'elle peut entraîner les EAF ou le SAF (Canada, 2005).

Les effets physiques, mentaux, émotionnels et comportementaux de l'exposition du fœtus à l'alcool varient beaucoup d'un sujet à l'autre. Le syndrome d'alcoolisation fœtale (SAF) se définit généralement par la présence de caractéristiques faciales distinctes, d'un retard de croissance et du dysfonctionnement du système nerveux central (Anderson et coll., 2002; Society, 1998; Tait, 2003; Van Bibber, 1997; Wemigwans, 2005). Quant aux effets de l'alcool sur le fœtus (EAF), ils désignent les effets comportementaux et cognitifs observés en l'absence des malformations physiques accompagnant le SAF. Il est donc difficile de déterminer les taux de prévalence et d'incidence des EAF parce que de nombreuses personnes exposées à l'alcool

avant leur naissance ne présentent pas de symptômes physiques évidents, mais plutôt des symptômes qui sont davantage d'ordre cognitif et comportemental. Comme ces symptômes sont plus difficiles à diagnostiquer, ils passent souvent inaperçus jusqu'à ce que l'enfant aille à l'école. Il s'ensuit que l'incidence réelle des EAF est probablement beaucoup plus élevée que les taux de SAF/EAF déclarés chez les nouveau-nés (Société canadienne de pédiatrie, 2002; Square, 1997). Outre le SAF et les EAF, l'expression « ensemble des troubles causés par l'alcoolisation fœtale (ETCAF) » est aussi utilisée pour désigner « l'ensemble des anomalies observées chez les personnes exposées à l'alcool avant leur naissance » [traduction] (Rasmussen, Horne et Witol, 2006). Cette expression sera généralement utilisée dans la présente section pour désigner les troubles causés par l'exposition prénatale à l'alcool, à moins d'une référence directe au SAF ou aux EAF.

On sait que la fréquence et la gravité des symptômes de l'ETCAF varient d'un sujet à l'autre, mais des données récentes semblent révéler la présence de différences au niveau des populations, soit entre les enfants autochtones et non autochtones. La littérature sur l'ETCAF fait état de certaines différences notables entre les populations autochtone et non autochtone au Canada. Par exemple, on estime que l'incidence globale du SAF au sein de la population canadienne en général se situe entre 2,8 et 4,8 par 1 000 naissances vivantes (Société canadienne de pédiatrie, 2002). À titre comparatif, le taux de SAF au sein des populations autochtones du nord du Manitoba était de 7,2 par 1 000 naissances vivantes (Société canadienne de pédiatrie, 2002). Selon l'ERS de 2002-2003, le taux de prévalence de l'ETCAF chez les Premières nations à l'échelle nationale est de 1,8 % (CGIPN, 2005).

Les comparaisons établies entre les taux de prévalence de l'ETCAF chez les Canadiens autochtones et non autochtones devraient toutefois être interprétées avec prudence, car les études sur l'ETCAF chez les Autochtones ont le plus souvent ciblé de petites communautés que l'on croyait susceptibles de présenter des cas d'exposition du fœtus à l'alcool en raison des taux élevés de consommation occasionnelle et excessive (Tait, 2003). Ces communautés ont donc tendance à présenter des taux de prévalence exceptionnellement élevés, allant même parfois jusqu'à une naissance sur cinq (Van Bibber, 1997). Par exemple, une étude menée sur la consommation d'alcool chez les femmes enceintes de l'île de Vancouver a révélé que 54 % des mères autochtones (Société canadienne de pédiatrie, 2002) et 16 % des mères non autochtones (Square, 1997) risquaient de mettre au monde un enfant souffrant de certains EAF. Outre le fait que les recherches aient été menées auprès de communautés à risque élevé, on considère souvent que d'autres facteurs pourraient aussi contribuer aux taux élevés de l'ETCAF qui sont observés au sein des communautés autochtones. Par exemple : les chercheurs s'attendent à observer des taux aussi élevés, un plus grand nombre de femmes autochtones que non autochtones donnent une description juste de leur consommation d'alcool pendant leur grossesse, une plus forte propension des professionnels de la santé à poser un diagnostic d'ETCAF chez les patientes autochtones et la présence de petits groupes de femmes qui consomment de l'alcool pendant plusieurs grossesses (Tait, 2003).

Les résultats des recherches sur l'ETCAF sont aussi faussés parce que les taux alarmants de prévalence observés chez certaines communautés autochtones (ou groupes d'individus) sont souvent généralisés à l'ensemble des Autochtones au Canada, et ce, sans données probantes et sans tenir compte de la diversité des peuples autochtones (Tait, 2003; Van Bibber, 1997). Grâce à d'autres recherches menées d'un bout à l'autre du pays, tant dans des secteurs à risque élevé

qu'à faible risque, il sera possible d'avoir une idée plus juste de l'étendue de l'ETCAF. Il importera aussi de prendre en considération les résultats observés aux États-Unis selon lesquels les taux de prévalence de l'ETCAF diffèrent entre les tribus indiennes américaines en fonction de la maîtrise et de la structure du gouvernement (Tait, 2003), car ces différences pourraient aussi influencer la stratification de l'ETCAF au Canada. Étant donné que l'ETCAF est largement reconnu comme la principale cause d'anomalies congénitales évitables chez les enfants autochtones (Canada, 2005; Society, 1998), il sera important d'en tenir compte pour l'étude de la santé à long terme de la population autochtone du Canada.

4. Facteurs de risque à la naissance

« D'un point de vue autochtone, chaque nouvelle vie peut être considérée comme une possibilité d'espoir et de guérison accordée par le créateur aux particuliers, aux familles, aux communautés et aux nations. Sur la roue médicinale [...], les nourrissons sont assis à côté des aînés. Comme les aînés, ils peuvent être considérés comme étant des enseignants. Les aînés et les nourrissons sont tous les deux proches du monde des esprits, les nourrissons en arrivant et les aînés s'y rendant. Cette proximité du monde des esprits peut apporter une force spirituelle, mais elle peut aussi causer une vulnérabilité physique et une sensibilité aux perturbations environnementales » (Centre des Premières nations, 2005).

Le terme « natal » désigne généralement des choses relatives ou associées à la naissance, ou présentes lors de la naissance de quelqu'un. Si la santé à la naissance revêt une telle importance, c'est que c'est au cours du premier mois de sa vie que le risque de mourir qui pèse sur un enfant est le plus élevé; pendant cette période, l'accouchement dans de bonnes conditions de sécurité et l'efficacité des soins néonataux sont essentiels (Organisation mondiale de la santé, 2007). De plus, les enfants sont exposés à d'importants facteurs de risque pouvant conduire au développement de maladies chroniques à ce stade; parmi eux, il y en a deux sur lesquels nous allons nous pencher expressément, à savoir un poids anormal à la naissance et l'absence d'allaitement maternel. Comme le démontreront les facteurs exposés ci-après, la santé des nourrissons autochtones est imbriquée dans les aspects maternel, familial et communautaire de la santé en général.

4.1 Poids anormal à la naissance

Le monde de la médecine occidentale fait du poids à la naissance un des plus importants instruments de mesure de la santé du nourrisson. Il en va ainsi parce qu'on peut se servir du poids à la naissance pour mesurer la croissance du fœtus, pour évaluer les conditions dans l'utérus et pour établir un lien entre ces facteurs du début de la vie et la santé à l'âge adulte (Centre des Premières nations, 2005). Plusieurs études ont mis en lumière la corrélation entre des modalités sub-optimales de croissance du fœtus et du nourrisson, d'une part, et les maladies chroniques chez les adultes, d'autre part. Ces études jettent les bases de ce qu'on appelle « l'hypothèse de l'origine fœtale », laquelle donne à penser qu'une « programmation » physiologique ou métabolique pendant la gestation et le début de la vie détermine, dans une large mesure, l'apparition de diverses maladies chroniques à un stade plus avancé de la vie (Barker, 1995, 1995, 1995; Hales et Barker, 1992). À titre d'exemple, diverses études ont fait état d'un lien étroit entre l'insuffisance pondérale à la naissance et l'apparition de maladies coronariennes

et d'hypertension plus tard dans la vie (Barker, 1995, 1995, 1995; Barker, Osmond et Law, 1989; Fall, Vijayakumar, Barker, Osmond et Duggleby, 1995; Kajantie, Barker, Osmond, Forsen et Eriksson, 2008). Des études de cohortes historiques en Angleterre ont permis de découvrir qu'un problème de croissance du fœtus, une insuffisance pondérale à la naissance et des infections des voies respiratoires inférieures dans la petite enfance sont susceptibles de causer une perte de fonctionnement des poumons à un stade avancé de la vie des adultes (Barker et coll., 1991; Shaheen et coll., 1994). Bien qu'une étude de suivi menée en 1985-1986 ne soit pas parvenue à confirmer cette conclusion (Shaheen, Sterne, Tucker et Florey, 1998), Barker et des collègues (1991) sont venus conforter quelque peu cette théorie en 1991 lorsqu'ils ont découvert un lien entre une insuffisance pondérale à la naissance et un mauvais fonctionnement des poumons à l'âge adulte. L'explication biologique de ce phénomène est que les influences intra-utérines qui ralentissent la prise de poids chez le fœtus entravent également la croissance des voies respiratoires et portent atteinte de manière permanente à leur développement et à leur fonctionnement (Barker, 2004). Cela dit, ces études souffrent d'un problème, c'est-à-dire que, souvent, elles tiennent pour acquis qu'un poids plus élevé à la naissance est plus sain; cette hypothèse ne tient pas compte de l'état de santé de la mère, par exemple, l'obésité et le diabète, lequel est susceptible de provoquer des changements dans le milieu de vie utérin, ce qui aura pour effet de produire des bébés plus lourds, mais pas nécessairement en meilleure santé (Chan, Wong et Silverman, 1990; Coory, 2000).

En guise d'exemple, il a été montré que tant le poids élevé (>4000 grammes) que faible (<2500 grammes) à la naissance sont liés à une augmentation du risque de diabète plus tard dans la vie (Harder, Rodekamp, Schellong, Dudenhausen et Plagemann, 2007; Pettitt, Forman, Hanson, Knowler et Bennett, 1997; Pettitt et Knowler, 1998). En dépit d'un accroissement du tabagisme pendant la grossesse parmi les femmes autochtones, dont il a été démontré qu'il diminue le poids à la naissance (Pirogowicz et coll., 2004; Wenman et coll., 2004), les populations d'Autochtones et de Canadiens ont des proportions similaires de naissances avec une insuffisance pondérale (Gilchrist et coll., 2004). Malgré des taux élevés de tabagisme maternel dans les communautés autochtones, les bébés des Premières nations ont presque deux fois plus de chances de se classer parmi les enfants présentant un poids élevé à la naissance que les Canadiens non autochtones (Rodrigues, Robinson, Kramer et Gray-Donald, 2000). Le poids médian à la naissance des enfants des Premières nations signalé au moment de l'Enquête régionale sur la santé (ERS) des Premières nations s'établissait à 3,55 kg et le poids médian des garçons (3,60 kg) était plus élevé que celui des filles (3,49 kg) (Centre des Premières nations, 2005). Si le poids médian à la naissance se situe plutôt vers le haut de la fourchette du « poids moyen à la naissance » (2,5-4,0 kg), on ne considère pas que la différence entre les sexes constitue une constatation importante : un poids plus élevé à la naissance chez les garçons a été signalé au sein de populations non autochtones (Centre des Premières nations, 2005). Une des préoccupations importantes que suscite le poids élevé à la naissance découle de sa corrélation avec l'aggravation de l'épidémie de diabète parmi les Autochtones (Caulfield, Harris, Whalen et Sugamori, 1998). Une étude récente des naissances chez les Premières nations en Saskatchewan de 1950 à 1984 a fait ressortir un lien digne de mention entre un poids élevé à la naissance (mais non pas un poids faible à la naissance) et le diabète dans le cas des Indiens inscrits vivant en Saskatchewan (OR 1.63 [95 % CI 1.20, 2.24]). On a également constaté que cette tendance était plus forte chez les filles que chez les garçons (Dyck et coll., 2001). Dans cette étude, les chercheurs ont estimé que l'excès de nutrition du fœtus est le facteur intra-utérin prépondérant débouchant sur la pathogénèse du diabète de type 2 parmi les Autochtones au Canada. Comme nous l'avons vu

plus haut, on croit aussi que la prévalence du diabète maternel a des incidences sur le poids à la naissance. Une étude menée en Saskatchewan parmi des femmes des Premières nations a permis de découvrir que les nourrissons issus de mères atteintes d'un diabète sucré de la grossesse (DSG) avaient 2,4 fois plus de risques d'être macrosomiques⁹ (95 % CI: 1.1, 5.6) que leurs contreparties dont la mère ne présentait pas de DSG (Dyck et coll., 2001). On a également constaté qu'un poids élevé à la naissance contribuait au développement de l'asthme chez les enfants. Sin et coll. (2004) sont arrivés à la conclusion que « parce que l'obésité favorise les inflammations et impose des contraintes mécaniques aux voies respiratoires, un poids élevé à la naissance peut être un facteur de risque d'asthme chez les enfants » [traduction] (Sin et coll., 2004). Étant donné qu'il a été constaté que les enfants autochtones ont un poids à la naissance plus élevé que les enfants non autochtones (Sin et coll., 2004; Thomson, 1990), ils courent peut-être un plus grand risque de contracter une maladie respiratoire chronique tôt dans leur vie.

Néanmoins, il importe d'éviter les généralisations abusives à propos de la prévalence d'un poids élevé à la naissance parmi les enfants autochtones. Cela tient au fait que, d'une part, des études, comme celles portant sur les Cris de la baie James, ont fait apparaître des statistiques médianes concernant le poids à la naissance qui sont parmi les plus élevées et une forte prévalence de macrosomie chez les nourrissons (Rodrigues et coll., 2000). De même, d'autres études donnent à penser que les enfants autochtones sont génétiquement prédisposés à une surcharge pondérale à la naissance (Sin et coll., 2004). Toutefois, un mauvais développement fœtal et une insuffisance pondérale à la naissance ont été constatés dans de nombreuses communautés indigènes défavorisées ou marginalisées (Blair, 1996; Chan, Keane et Robinson, 2001), où le manque d'accès à des éléments de subsistance fondamentaux et à des soins médicaux place les mères et leurs nourrissons en situation de risque. De mauvaises conditions de vie, des problèmes socio-économiques et des soins de santé maternelle inadéquats dans bon nombre de communautés autochtones du Canada font courir à ces nourrissons un risque élevé d'insuffisance pondérale à la naissance (Blair, 1996; Chan et coll., 2001). C'est pourquoi il faut mener des recherches plus poussées et mieux comprendre ce facteur de risque afin de pouvoir tirer des conclusions à son sujet (Kuh et Ben-Shlomo, 2004).

Une dernière observation s'impose à propos des divers classements du poids à la naissance. En ce moment, le poids à la naissance des Autochtones est classé comme étant élevé, normal ou insuffisant en comparaison des normes applicables aux non-Autochtones. En raison des différences potentielles entre les populations autochtones et non autochtones du point de vue de la santé maternelle et infantile, il convient de considérer que les comparaisons entre les divers poids à la naissance sont, tout au mieux, approximatives et préliminaires. Nous aurons besoin à l'avenir de mesures plus appropriées et culturellement adaptées afin d'établir des statistiques plus exactes permettant d'évaluer ce facteur de risque dans le contexte autochtone.

4.2 Allaitement maternel

Il est fréquemment question d'allaitement maternel dans le domaine de la santé natale. La popularité de l'allaitement au sein a varié au fil du temps et elle fluctue toujours en fonction de réalités et de points de vue culturels; il existe une littérature de plus en plus abondante qui traite de ses répercussions sur la santé et le développement des nourrissons.

⁹ Cela veut dire qu'ils ont un poids élevé à la naissance (>4000 g).

Santé Canada encourage les mères à allaiter, car cette façon de faire procure aux nourrissons un apport nutritif et émotionnel, ainsi que des avantages immunologiques, qui rehaussent leur croissance et leur développement (Agence de la santé publique du Canada, novembre 1998). On considère que l'allaitement maternel est un aspect important de la prévention des maladies, parce que les nourrissons alimentés au sein bénéficient d'une meilleure protection contre les infections respiratoires, otiques et intestinales. Cela découle du fait que les composantes propres au lait maternel protègent les nourrissons contre les infections venant de l'extérieur (Agence de la santé publique du Canada, novembre 1998). Les recherches indiquent que les enfants allaités courent moins de risque de présenter un excès pondéral et ont davantage de chances d'avoir un poids acceptable et d'être en « très bonne » ou « excellente » santé. Ces résultats étayaient la littérature consacrée aux avantages estimatifs de l'allaitement. Outre les avantages sur le plan de la santé, l'allaitement offre des bienfaits d'ordre social et économique, car il est une source de nourriture écologiquement saine, efficace, économique et favorisant l'autosuffisance (Comité canadien pour l'allaitement, 2002; Agence de la santé publique du Canada, novembre 1998).

Comme tous les bébés nés avant l'avènement des laits maternisés, les nourrissons autochtones étaient allaités jusqu'à ce qu'ils puissent digérer d'autres sources de nourriture (Banks, 2003). Toutefois, la pratique traditionnelle de l'allaitement au sein a cédé la place à l'alimentation au biberon dans les années 1950, lorsque les laits maternisés ont été mis à la disposition de la population (MacMillan et coll., 1996). À titre d'exemple, une étude réalisée auprès d'enfants autochtones au Manitoba a établi que l'allaitement maternel prolongé constituait un puissant facteur de protection contre le diabète de type 2; il a été montré qu'un enfant nourri au sein pendant plus de 12 mois courait un risque de diabète représentant seulement 24 % pesant sur un enfant alimenté au biberon (Young, Chateau et Zhang, 2002). Les effets protecteurs de l'allaitement au sein ont également été observés dans des études sur les Indiens Pima (Pettitt et coll., 1997; Pettitt et Knowler, 1998). En dépit de ces études et du fait que les taux d'adoption de l'allaitement maternel ont progressé ces dernières années (Langner et Steckle, 1991; Macaulay, Hanusaik et Beauvais, 1991), les statistiques limitées sur les taux d'allaitement maternel chez les Autochtones révèlent que cette façon de faire est moins répandue que dans la population en général (Dodgson, Duckett, Garwick et Graham, 2002).

C'est ainsi qu'une enquête réalisée en 1988 pour le compte de la Base nationale de données sur l'allaitement maternel chez les Indiennes et les Inuits a révélé que 60,7 % des nourrissons étaient allaités au sein à la naissance, mais que ce taux connaissait ensuite un recul marqué, s'établissant à 31,1 % chez les bébés de six mois (Langner et Steckle, 1991). Une étude plus récente menée auprès des Cris de la baie James a fait apparaître un taux initial d'allaitement de 51,9 % chez les mères autochtones (Black, Godwin et Ponka, 2008). La proportion moyenne d'enfants qui, selon l'ERS 2002-2003, sont nourris au sein était de 62,5 % (Centre des Premières nations, 2005). Comme on le fait observer dans l'ERS : « Ce taux est plus élevé que le taux précédent (50 p. 100) relevé pour les Premières nations et les Inuits » (Comité directeur national de l'enquête régionale sur la santé des Premières nations et des Inuits, 1999) » [traduction]. Toutefois, il est inférieur au taux (79,9 %) dont il a été fait état pour la population canadienne en général (Statistique Canada, 1998-1999). L'ERS a également rendu compte de la durée de l'allaitement maternel : « Parmi les enfants qui ont été nourris au sein, 21,6 % l'ont été pendant 12 semaines ou moins, 35 % ont été alimentés au sein pendant trois à six mois et 43,3 % l'ont été pendant plus de six mois. » [traduction] (Centre des Premières nations, 2005). Il a été constaté que ces taux étaient plus élevés que ceux relevés dans l'ERS de 1997 (seulement 22,5 % ont fait

état d'un allaitement maternel durant plus de sept mois) (Comité directeur national de l'enquête régionale sur la santé des Premières nations et des Inuits, 1999). En comparaison de la population canadienne, 32,5 % ont indiqué avoir allaité au sein pendant 12 semaines ou moins, 33,4 % de trois à six mois et 34,0 % pendant plus de six mois (Statistique Canada, 1998-1999).

Les réalités socio-culturelles, politiques et économiques liées à l'allaitement au sein sont complexes (Banks, 2003). À titre d'exemple, le succès ou l'échec de l'allaitement maternel chez de nombreuses femmes autochtones est fonction de multiples facteurs intergénérationnels et communautaires. Parmi les femmes mohawks, la pratique de l'allaitement dépend dans une large mesure de la grand-mère du bébé, laquelle joue un rôle clé dans l'éducation de l'enfant. De ce fait, les taux d'allaitement au sein sont fréquemment bas, car cette façon de nourrir le nourrisson est peu pratique lorsque la grand-mère et la famille élargie sont censées y participer. Étant donné que l'allaitement au biberon facilite la participation de la famille élargie, et du fait que la technologie de la pompe et les moyens d'entreposage ne sont pas toujours disponibles, les pratiques en matière d'allaitement tendent à différer de celles qu'on trouve dans l'ensemble de la population (Banks, 2003). D'autres facteurs culturels, comme la disponibilité de laits maternisés subventionnés par les gouvernements (Banks, 2003), peuvent faire baisser les taux d'allaitement au sein. En outre, chez les mères qui ont un faible revenu, des antécédents familiaux de fréquentation de pensionnats autochtones ou de vie dans une communauté ayant un accord multi-communauté dans le domaine des soins de santé, la pratique de l'allaitement maternel était moins répandue et de plus courte durée (Centre des Premières nations, 2005). Cette information provenant de l'ERS 2002-2003 est utile, mais il faut étudier plus en profondeur les liens entre l'allaitement et ces facteurs, et d'autres aussi, par exemple, l'éducation (Comité canadien pour l'allaitement, 2002). Le lien dont fait état l'ERS entre une surcharge pondérale à la naissance, l'allaitement maternel et le non-tabagisme chez les mères mérite également l'attention (Centre des Premières nations, 2005).

5. Facteurs de risque chez la petite enfance

On entend par « petite enfance » les enfants âgés d'un à cinq ans. Il est fréquent que cette tranche d'âge soit traitée à part, car c'est à cette période que les enfants connaissent une phase de croissance accélérée. Cette période est particulièrement importante pour la santé, car cette phase de croissance peut influencer sur la santé et le développement à long terme d'une personne : « De bonnes fondations dans les premières années de la vie font la différence à l'âge adulte et permettent [même] de donner un meilleur départ à la génération suivante. » (Organisation mondiale de la santé, 2008).

S'il est vrai que le soin des enfants, pendant cette période, incombe souvent à leurs parents, on reconnaît de plus en plus qu'il est extrêmement important que les prestataires de services, les planificateurs et les décideurs possèdent une connaissance approfondie de la petite enfance et qu'ils aident à répondre aux besoins sociaux, économiques et biologiques de tous les enfants (Centres d'excellence pour le bien-être des enfants, 2008). S'il est si nécessaire de mettre l'accent sur cette période, c'est que, malheureusement, c'est la première fois dans l'histoire que les parents peuvent dire avec certitude que l'espérance de vie de leurs enfants sera probablement moins grande que la leur (Alliance pour la prévention des maladies chroniques au Canada, 2006). Dans le but de mieux faire comprendre les répercussions de la petite enfance plus tard dans la vie, nous présentons dans cette section les principaux facteurs de risque de contracter une des

maladies chroniques présentes chez les enfants autochtones. Avant cela, toutefois, voici une description de la population visée.

5.1 Influences sur la population

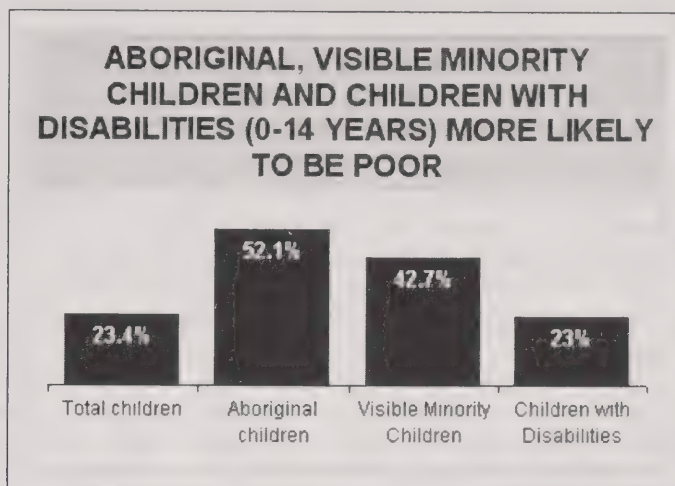
L'une des caractéristiques marquantes de la population autochtone au Canada tient à son jeune âge et à son nombre proportionnellement élevé. Il s'ensuit que la population autochtone représente le groupe dont la croissance est la plus rapide au pays (le taux de natalité est de 70 % supérieur à celui de la population non autochtone) (Statistique Canada, 1996) et que les enfants autochtones constituent une part importante de l'ensemble de la population autochtone. Selon un rapport publié par le Conseil canadien de développement social (CCDS) en 2002, les enfants âgés de moins de 14 ans représentent le tiers de la population autochtone, ce qui est sensiblement plus que la proportion de 19 % de la même tranche d'âge des enfants non autochtones (Anderson, 2003). En outre, des statistiques de 2002 montrent que les enfants autochtones représentent 5,6 % du total des enfants au Canada, alors que la population autochtone, au total, ne compte que pour 3,3% de la population du Canada (Anderson, 2003). En raison du pourcentage important des enfants autochtones dans la population totale et du fait qu'ils représentent l'avenir, il faut estimer que leur santé et leur bien-être méritent une attention prioritaire. Nous traiterons des facteurs de risque de maladies chroniques auxquels ces enfants sont le plus exposés et ayant le plus de répercussions sur l'enfance, afin que nous puissions mieux comprendre la santé et le bien-être actuels et futurs des enfants autochtones au Canada.

5.2 Pauvreté et faim chez les enfants

Environ 20 millions d'enfants de moins de cinq ans, dans le monde entier, sont sévèrement malnutris et vivent dans la pauvreté. De ce fait, ces enfants sont davantage vulnérables à la maladie et susceptibles de mourir en bas âge (Organisation mondiale de la santé, 2008). Bien que les termes de pauvreté et de faim évoquent souvent les pays en développement, la réalité de la pauvreté infantile au Canada est très réelle : un enfant sur six au Canada est pauvre. Cela représente un taux de pauvreté infantile de 15 %, trois fois les taux observés en Suède, en Norvège et en Finlande (campagne « Abolissons la pauvreté »). La pauvreté chez les enfants autochtones est encore plus affligeante. Certes, certaines des statistiques sont contradictoires, mais environ un enfant des Premières nations sur quatre vit dans la pauvreté (Campagne 2000, 2006). Toutefois, un rapport datant de 2001 a montré que plus de la moitié (52,1 %) des enfants autochtones étaient pauvres (Lee, 2000).

Après ventilation des statistiques visant les enfants vivant dans et hors réserve, le grand nombre d'enfants autochtones vivant dans la pauvreté apparaît encore plus clairement. Cela tient au fait que 40 % des enfants vivant à l'extérieur des réserves se trouvent dans une situation de pauvreté (Campagne 2000, 2006). Et puisque 219 570 des 286 500 enfants autochtones vivent hors réserve, cela signifie que 77 % de tous les enfants autochtones ayant de zéro à neuf ans (Lee, 2000) peuvent être considérés comme vivant dans la pauvreté. Cette statistique, choquante par son niveau élevé, représente le taux le plus fort parmi les trois groupes visés par la problématique de l'équité illustrée dans la figure ci-dessous (Lee, 2000).

Figure 5. Prévalence de la pauvreté infantile chez les enfants autochtones, les enfants des minorités visibles et les enfants handicapés



Source : (Conseil canadien de développement social, 2003); source initiale : Statistique Canada, recensement de 1996, avec un calcul personnalisé pour le compte du Conseil canadien de développement social.

**ENFANTS AUTOCHTONES, DE MINORITÉS VISIBLES ET HANDICAPÉS
(0-14 ANS) PLUS SUSCEPTIBLES D'ÊTRE PAUVRES**

23,4 % 52,1 % 42,7 % 23 %

Total des enfants, Enfants autochtones, Enfants de minorités visibles, Enfants handicapés

Note : Dans ce tableau, « Autochtones » s'entend des personnes qui se sont identifiées comme étant des Amérindiens, des Métis ou des Inuits. On définit les personnes appartenant à une minorité visible, au sens de la *Loi sur l'équité en matière d'emploi* (1986), comme étant celles (autres que les personnes autochtones) qui sont de race non caucasienne ou ne sont pas de couleur blanche. Des personnes sont classées parmi les « personnes handicapées » d'après leurs réponses à des questions concernant des limitations à leur activité ou leur handicap.

Certes, les statistiques relatives à la pauvreté chez les enfants autochtones sont choquantes, mais le véritable objet de la préoccupation qu'inspirent ces chiffres concerne les répercussions de cette situation sur la santé des populations autochtones aujourd'hui et demain. Cela tient au fait que « les taux de pauvreté sont des indicateurs de la santé des citoyens et de l'état des instituts. De même, les taux de pauvreté sont des variables permettant de prédire des enjeux de santé à long terme chez les enfants » [traduction] (Ontario Federation of Indian Friendship Centres, 2004). Indépendamment de l'interprétation que l'on peut faire des chiffres, donc, on peut tirer la conclusion que des risques sévères pèsent sur la santé actuelle et future des enfants autochtones.

5.2.1 Impact de la pauvreté infantile sur la santé à l'âge adulte

On peut logiquement poser comme hypothèse que le statut socio-économique d'un adulte dépend de ce qu'il était pendant l'enfance. Mais étant donné que ce ne sont pas tous les adultes dont le statut socio-économique est mauvais qui ont grandi dans une mauvaise situation socio-

économique (et inversement), il faut comprendre les schèmes du statut socio-économique tout au long du parcours de vie pour établir ses liens avec l'état de santé d'une personne donnée.

Il est maintenant bien accepté que le vécu de l'enfance peut façonner la santé à l'âge adulte par l'intermédiaire du dénuement matériel et de son influence sur les réalités et le comportement que l'on vit comme adulte. De plus en plus d'éléments de preuve donnent à penser que le vécu pendant l'enfance a également des incidences sur la santé pendant la phase de développement, particulièrement par l'intermédiaire de l'activation des systèmes de réaction au stress (Boyce & Keating, 2004). Comme l'ont fait ressortir McEwen et ses collègues, les réactions récurrentes au stress provoquées en début de vie par des milieux sociaux défavorables peuvent entraîner des changements physiologiques durables, comme des altérations du métabolisme des lipides et l'accumulation de la masse grasse, le développement de l'hypertension et le développement de l'insulinorésistance qui débouche sur le diabète sucré de type 2 et les maladies cardiovasculaires (McEwen, 2006). Plusieurs autres études ont démontré le lien entre la pauvreté à l'enfance et les maladies chroniques à un stade ultérieur de la vie (Cohen et Reutter, 2007; Everson, Maty, Lynch et Kaplan, 2002; Galobardes, Lynch et Davey Smith, 2004; Lawlor et Smith, 2005; Poulton et coll., 2002; Power et coll., 2007). Selon une étude norvégienne, le risque le plus élevé de mortalité chez les hommes et les femmes a été observé dans le groupe dont les membres étaient pauvres à la fois pendant l'enfance et à l'âge adulte; cela démontre clairement l'influence cumulée des réalités sociales pendant tout le parcours de vie sur le risque de mortalité (Claussen, Davey Smith et Thelle, 2003). Dans la même étude, la mortalité de cause cardiovasculaire a été associée plus étroitement avec les réalités sociales de l'enfance que de l'âge adulte. Ainsi, les effets latents de la pauvreté sur la santé des adultes montrent que la courbe de la santé commence à apparaître à l'enfance (Graham et Power, 2004; Moody-Ayers, Lindquist, Sen et Covinsky, 2007; Poulton et coll., 2002). On considère que cela est attribuable, dans une large mesure, à un certain nombre de facteurs qui se recoupent, dont, sans que cette mention ne soit exhaustive, la mauvaise qualité de la nutrition et le manque d'accès aux soins de santé (Graham et Power, 2004). En outre, on pense que le façonnement du comportement et des habitudes de vie, qui se fait pendant l'enfance, a un effet profond sur la santé et le développement futurs.

5.2.2 Faim et sécurité alimentaire

Est profondément lié à la pauvreté le manque de nutriments ou l'incapacité d'avoir accès, d'acheter et de consommer une quantité suffisante d'aliments comportant assez de nutriments. Il ne faut donc pas s'étonner de ce que la préoccupation la plus pressante des enfants autochtones vivant dans la pauvreté soit le manque de nourriture. En fait, le Conseil canadien de développement social a constaté que les enfants autochtones courent quatre fois plus de risques de connaître la faim que toute autre minorité ethnique au Canada (Anderson, 2003; McIntyre, 2003). Pour comprendre les conséquences de cette situation sur la santé des enfants vivant dans la pauvreté, nous devons nous pencher sur la malnutrition et sur ses répercussions sur la santé.

Selon McIntyre (2003), « on définit la malnutrition comme étant la non-satisfaction des besoins de nutriments, ce qui peut nuire à la santé physique ou mentale » [traduction] (McIntyre, 2003). Ainsi, certains effets courants de la malnutrition provoquée par la pauvreté sur la santé sont d'ordre mental, alors que d'autres sont de nature physique (Ontario Federation of Indian Friendship Centres, 2004). En guise d'exemple, on a établi un lien entre la capacité d'un enfant de se concentrer à l'école et sa consommation d'aliments, particulièrement avec l'accès des enfants au déjeuner. Le blocage de la croissance ou une

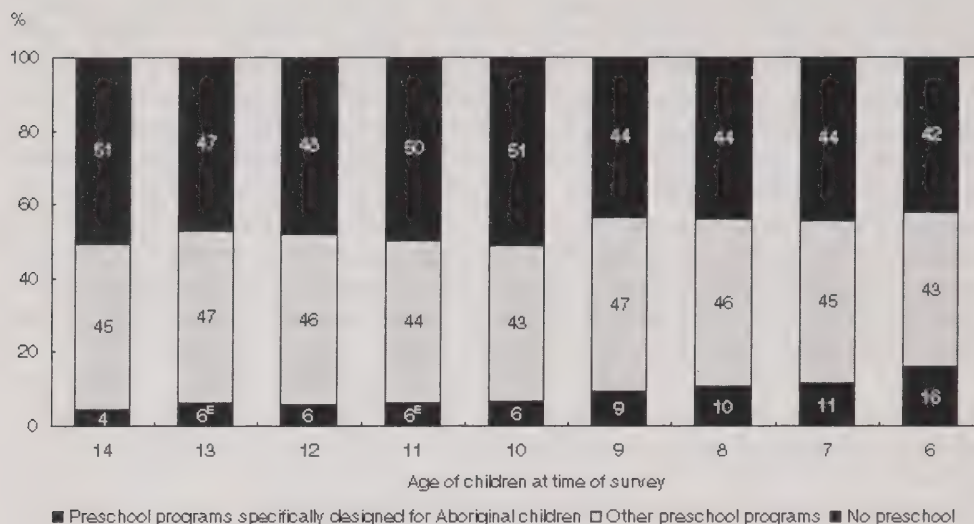
taille inférieure à la normale pour l'âge, dont on peut dire qu'ils sont les facteurs les plus révélateurs de la malnutrition, démontrent les aspects davantage physiques d'une consommation insuffisante de nourriture (McIntyre – sécurité alimentaire, options stratégiques). La malnutrition pose également le problème de la prise et de l'absorption insuffisantes d'importants micronutriments, par exemple le fer, l'iode et la vitamine A (McIntyre, 2003). Certes, le terme « malnutrition » est utile et décrit bien le problème de la faim dans les pays en développement, mais on a fait valoir qu'il vaut mieux employer l'expression « sécurité alimentaire » lorsqu'on a décrit la faim dans les sociétés développées comme celle du Canada. McIntyre (2003) donne de l'insécurité alimentaire la description suivante : « l'incapacité d'obtenir ou de consommer un régime alimentaire de qualité suffisante ou de la nourriture en qualité suffisante de manière socialement acceptable ou le manque de certitude quant à sa capacité de le faire » [traduction]. Qu'on parle d'insécurité alimentaire ou de nutrition, la capacité de la personne d'atteindre avec régularité le niveau nutritionnel requis est un déterminant clé de la santé (Ontario Federation of Indian Friendship Centres, 2004).

Certes, les répercussions précises de la faim chez un enfant sur la santé et le développement à long terme sont complexes et elles interagissent avec les expériences de faible statut socio-économique qui prédisposent souvent les enfants à la faim, mais il importe de se souvenir que « la faim chez l'enfant est la manifestation extrême de l'insécurité alimentaire d'un ménage » [traduction] (McIntyre, 2003). C'est pourquoi un angle communautaire est éclairant.

Apprentissage et développement du jeune enfant

Outre la croissance et le développement physiques, il se fait beaucoup de développement intellectuel et social pendant les premières années. Souvent, cette croissance sur les plans cognitif et social se voit facilitée par des activités familiales et communautaires, ainsi que par la participation à des programmes de grande qualité concernant le développement de la petite enfance ou des programmes préscolaires (Palacio-Quintin, 2000; Statistique Canada, 2001). Selon l'Enquête auprès des peuples autochtones (EAPA) de 2001, à peine plus de la moitié (53 %) des enfants autochtones âgés de 6 à 14 ans et vivant à l'extérieur de réserves avaient suivi un programme de développement de la jeune enfance lorsqu'ils étaient plus jeunes (Statistique Canada, 2001). Moins d'enfants inuits (35 %) que des Premières nations (54 %) ou métis (57 %) avaient participé à un programme préscolaire. Toutefois, les programmes axés expressément sur les besoins des enfants autochtones se font plus nombreux et les taux d'inscription à des programmes de développement de la petite enfance et de rétention semblent avoir beaucoup augmenté : « chez les jeunes de 14 ans, seulement 4 % ont pu profiter, lorsqu'ils étaient plus jeunes, d'un programme préscolaire conçu spécifiquement pour les enfants autochtones. Cette proportion est beaucoup plus élevée pour les enfants qui avaient 6 ans au moment de l'enquête. En effet, 16% des enfants autochtones vivant hors réserve et âgés de 6 ans au moment de l'enquête avaient fréquenté, à un moment ou l'autre de leur enfance, un programme préscolaire spécialement conçu pour les enfants autochtones. » (Statistique Canada, 2001). Comme le montrent ces statistiques, la fréquentation de l'école maternelle par les enfants autochtones varie beaucoup selon leur année de naissance et leur ascendance autochtone. Ce constat est démontré dans la figure qui suit.

Figure 6. Aboriginal children in non-reserve areas who ever attended preschool programs, Canada, 2001



Note: Percentages in this chart may not add up to 100% due to rounding.

Source: Statistics Canada, Aboriginal Peoples Survey, 2001.

Source: (Statistique Canada, 2001)

Figure 6. Enfants autochtones vivant hors réserve qui ont fréquenté un programme préscolaire, Canada, 2001

Âge de l'enfant au moment de l'enquête

Programmes préscolaires destinés aux Autochtones

Autres programmes préscolaires

Aucun programme préscolaire

Note : La somme des pourcentages de ce tableau n'est pas toujours de 100 % en raison de l'arrondissement

Source : Statistique Canada, Enquête auprès des peuples autochtones de 2001

Source : Statistique Canada, 2001

La figure ci-dessus, qu'on trouve dans le site Web de Statistique Canada (Statistique Canada, 2001) montre qu'en l'espace de huit ans, la proportion des enfants autochtones vivant hors réserve fréquentant des programmes préscolaires conçus pour eux s'est multipliée par quatre. En dépit de ces progrès, les chiffres absolus demeurent peu élevés : « si un enfant autochtone vivant hors réserve sur deux a déjà fréquenté un programme préscolaire ou de développement de la petite enfance, il n'en demeure pas moins que seulement un enfant autochtone vivant hors réserve sur six a fréquenté un programme spécifiquement conçu pour les enfants autochtones » (Statistique Canada, 2001). Étant donné qu'il ne s'est pas produit de changement statistiquement important en ce qui concerne la proportion d'enfants autochtones suivant des programmes préscolaires généraux (c'est-à-dire, ne s'adressant pas expressément aux Autochtones), il y a des raisons de croire que le potentiel de croissance et de développement dans ce domaine est fonction de programmes personnalisés. On espère que des programmes de cette nature encourageront une plus grande participation à l'éducation de la petite enfance et permettront aux enfants d'acquérir des aptitudes sociales et intellectuelles – qui sont toutes deux d'une importance cruciale pour assurer leur bien-être à long terme et leur bon fonctionnement dans le

monde. On croit aussi que les programmes de ce type prépareront les enfants à fréquenter l'école plus longtemps et réduiront les taux de décrochage scolaire parmi les élèves autochtones au secondaire. En fait, de nombreux auteurs (Cairns, Cairns et Neckerman, 1989) ont montré que les taux de décrochage scolaire sont liés aux cinq premières années d'un enfant à l'école. Ce constat met en évidence une fois de plus le fait que l'éducation et l'apprentissage, particulièrement au cours des premières années de l'enfant, revêtent une importance décisive pour le succès de chaque personne et pour la prospérité de la communauté (Cardinal, 2004).

5.4 Tabagisme chez les parents et fumée à la maison

Comme nous l'avons vu plus haut, les facteurs environnementaux peuvent influencer sur le risque que court une personne de contracter des maladies chroniques à toutes les étapes de la vie. Cela dit, il importe de faire observer que certains groupes sont plus vulnérables que d'autres à l'environnement des ménages. C'est le cas des enfants : ils passent plus de temps à l'intérieur et, aussi, ils sont exposés à l'environnement du ménage pendant leur développement, fait qui renforce les répercussions de l'exposition à l'environnement des ménages. Cela tient au fait que des expositions pendant de longues périodes de temps à des facteurs de risque environnementaux peuvent avoir des incidences nocives sur la croissance, le développement et le fonctionnement à un stade ultérieur de la vie (Sin, Sharpe, Cowie et Man, 2004). Dans cette section, nous nous pencherons sur les conséquences de la consommation traditionnelle et non traditionnelle du tabac, ainsi que de l'utilisation de poêles consommant du charbon ou du bois.

On évoque fréquemment la consommation de tabac en la limitant à sa dimension d'habitude et de pratique individuelles. Cela faisant, on oublie fréquemment que les habitudes et pratiques des parents et d'autres aidants peuvent avoir des répercussions sur la santé et le développement de leur enfant au-delà du stade de la petite enfance. La prévalence et les conséquences du tabagisme sont abordées dans les sections consacrées à l'âge adulte et à l'adolescence; dans celle-ci, nous mettons l'accent sur les répercussions de la fumée secondaire sur les enfants. Il est bien documenté que le tabagisme d'habitude et le tabagisme passif constituent des problèmes importants dans de nombreuses communautés autochtones. C'est ainsi qu'il a été découvert dans des études que de nombreux enfants autochtones vivent dans des maisons où un parent fume, voire les deux. Cela est particulièrement courant dans le cas des enfants ayant des problèmes respiratoires et d'autres maladies chroniques. En guise d'exemple, dans une étude d'enfants de Premières nations, 73 % de ceux signalant une obstruction des voies respiratoires vivaient dans une maison où un parent ou les deux fumaient (Orr et coll., 2001). Des taux élevés de tabagisme parental ont également été consignés dans une étude de 1995-1996 sur la bronchiolite parmi les enfants inuits : le tabagisme parental survenait dans 42 des ménages (48,8 %) où vivaient les 86 enfants faisant l'objet de l'étude et, dans 31 autres ménages, les parents ont indiqué qu'ils fumaient à proximité de la maison; seulement dans trois ménages les parents se sont-ils dits non-fumeurs (Mann, Wadsworth et Colley, 1992). Il ne faut donc pas s'étonner du fait que la littérature démontre aussi que le tabagisme exacerbe les risques de maladies respiratoires chroniques pendant les premières années de la vie (Millar, 1992; Sin et coll., 2002). Le raisonnement d'ordre physiologique qui sous-tend ce constat est que la fumée cause des atteintes au système respiratoire qui favorisent ou aggravent le développement de problèmes respiratoires chroniques (Alwyn, 2004). Au fur et à mesure que les effets du tabagisme s'accumulent sur la durée de la vie, l'exposition à la fumée à un jeune âge cause un grand risque de développement de maladies chroniques associées à la cigarette, comme le diabète, les maladies cardiovasculaires

et des problèmes respiratoires, plus tard dans la vie. Pour ces raisons, il importe de prendre en considération le milieu de vie et les situations auxquelles les enfants sont exposés, du fait des choix de style de vie de leurs parents et leur milieu à la maison. Nous abordons brièvement ci-après l'influence de la fumée à la maison.

Un autre facteur peut contribuer à la fumée dans la maison, à part le tabagisme direct des parents ou de membres du ménage, à savoir l'utilisation de poêles à charbon ou à bois pour le chauffage, l'eau chaude et la cuisson; de plus, la mauvaise structure de nombreuses maisons des Autochtones fait que la fumée de l'extérieur pénètre dans la maison (Cardinal, 2004; Petersen et coll., 2003). Comme la fumée passive, la fumée à l'intérieur de la maison peut causer des atteintes considérables au système pulmonaire et nuire à la respiration normale ou à la croissance, au développement et au fonctionnement des poumons et d'autres organes du système pulmonaire (Harris et coll., 1998). De plus, l'effet conjugué de la mauvaise qualité de l'air, de l'utilisation de poêles à bois, de mauvaises conditions de logement et d'une mauvaise santé respiratoire chez l'enfant dans de nombreuses communautés autochtones est préoccupant (Alliance pour la prévention des maladies chroniques au Canada, 2006).

6. Facteurs de risque à l'enfance et à l'adolescence

Bien qu'il soit important de prendre en considération les premiers stades du développement de l'enfance quand il est question de la santé et du bien-être d'une personne durant sa vie, la santé à l'enfance et à l'adolescence revêt elle aussi de l'importance. Et, tout comme la petite enfance constitue un stade important du développement et de la croissance, il en va de même de la maturation physique (changements sexuels et corporels) qui se produit à l'adolescence. De plus, les changements psychologiques et sociaux importants qui se produisent parallèlement aux changements physiques font de cette période un stade crucial du passage à l'âge adulte. Puisque certains facteurs de risque clés comme l'obésité, le tabagisme et la sédentarité sont toujours beaucoup plus présents chez les enfants et jeunes autochtones comparativement à la moyenne nationale du Canada (Guo, Roche, Chumlea, Gardner et Siervogel, 1994; Serdula et coll., 1993), il est important de tenir compte de la santé de cette cohorte tout au long de sa vie.

6.1 L'obésité infantile

Dès études longitudinales portant sur la population en général ont démontré que l'embonpoint ou l'obésité à l'enfance et à l'adolescence sont liés au diabète juvénile et précurseurs de l'obésité à l'âge adulte (Barrett-Connor, 1989), qui est associée au diabète de type 2 (Hubert, Feinleib, McNamara et Castelli, 1983) et à la coronaropathie (Kumanyika, 1993). Bien que des études aient révélé des taux élevés d'obésité infantile chez plusieurs autres groupes raciaux (Bernard, Lavalley, Gray-Donald et Delisle, 1995), le taux d'obésité des enfants autochtones est particulièrement élevé (Tjepkema, 2002) : plusieurs études ont démontré que le poids des enfants autochtones est plus élevé (en moyenne) que celui des autres enfants canadiens (Young, Dean, Flett et Wood-Steiman, 2000). Une étude réalisée auprès d'enfants autochtones de 4 à 19 ans a révélé des taux de prévalence de l'obésité inquiétants : 64 % des filles et 60 % des garçons étaient considérés obèses. Cette étude a également démontré que l'obésité prédisposait davantage les enfants au diabète (MacMillan et coll., 1996). Cependant, il est important de noter que l'indice de masse corporelle (IMC) des enfants autochtones de l'Arctique doit être interprété avec circonspection, car la courbe de croissance de ces enfants est différente en raison du rapport poids-taille élevé nécessaire pour survivre dans le climat sous lequel ils vivent (MacMillan et

coll., 1996). On ne devrait donc pas confondre cette courbe de croissance différente et l'obésité (Reilly et coll., 2005).

Afin de comprendre l'étiologie de l'obésité infantile chez les enfants autochtones, il est important d'examiner les causes rapportées dans la littérature sur les Autochtones et la population générale. Une enquête longitudinale britannique dirigée par Reilly et coll. (en 2005) s'est intéressée de près aux facteurs de risque précoces de l'obésité infantile. En plus des liens déjà mentionnés entre l'obésité infantile et le poids élevé à la naissance et l'obésité des parents (voir la partie sur les facteurs de risque prénataux), les chercheurs ont découvert que les enfants qui regardaient la télévision pendant plus de huit heures par semaine risquaient davantage de devenir obèses (Reilly et coll., 2005). La durée du sommeil était également associée de manière indépendante à l'obésité infantile : les enfants de 30 mois se situant dans les deux premiers quartiles (ceux qui dormaient 10,5 heures et entre 10,5 et 10,9 heures) avaient plus de chances d'être obèses à 7 ans que les enfants du dernier quartile (> 12 heures). On explique cette corrélation de la façon suivante : bien que regarder la télévision réduise la dépense d'énergie, la durée du sommeil, elle, modifie la sécrétion de l'hormone de croissance, change l'exposition des enfants aux facteurs favorisant l'obésité, comme manger en soirée, et sert d'indicateur d'un niveau d'activité physique adéquat (Hanley et coll., 2000).

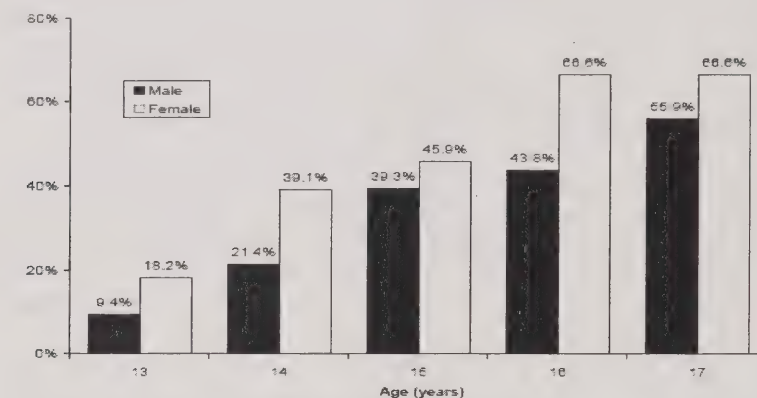
De plus, une étude menée dans la communauté autochtone de Sandy Lake a examiné la corrélation entre l'obésité et les heures passées à regarder la télévision (Hanley et coll., 2000). Cette étude a démontré que les enfants qui regardaient la télévision pendant plus de cinq heures par jour avaient 2,5 fois plus de chances de prendre (ou d'avoir déjà) de l'embonpoint que les enfants qui écoutaient moins de deux heures de télévision par jour (Hanley et coll., 2000). La même étude a également révélé que les enfants qui faisaient plus d'exercice et dont l'alimentation était plus riche en fibres avaient moins de chances d'avoir de l'embonpoint (Comité de gouvernance de l'information des Premières nations, Enquêtes régionales sur la santé réalisées par les Premières nations et les Inuits, Comité de direction, Centre des Premières nations et Organisation nationale de la santé autochtone, 2004). Selon l'Enquête régionale sur la santé (ERS) des Premières nations et des Inuits de 1997, 98 % des enfants regardaient la télévision toutes les semaines pendant en moyenne 2,9 heures par jour (Bernard et coll., 1995; Ng, Marshall et Willows, 2006). D'autres études sur les Autochtones ont constaté que les écoliers et les adolescents cris qui avaient de l'embonpoint faisaient beaucoup moins d'activité physique et mangeaient beaucoup moins de portions de fruits et de légumes que leurs pairs d'un poids normal (Comité de gouvernance de l'information des Premières nations et coll., 2004)., Lorsqu'ils ont été interrogés dans le cadre de l'ERS sur l'accessibilité à des installations sportives et culturelles dans leur communauté, moins de la moitié des jeunes Autochtones ontariens ont indiqué avoir accès à des installations sportives. Les besoins les plus fréquemment mentionnés étaient dans l'ordre les suivants : une piscine communautaire, du matériel pour les terrains de jeux, un aréna et un centre de loisirs de jour (Ritchie et Reading, 2004). Les problèmes d'obésité dans les communautés autochtones de l'ensemble du pays sont liés à un mode de vie de plus en plus sédentaire, au manque d'exercice et à une mauvaise nutrition, et ces facteurs prédictifs devraient être mieux compris et ciblés afin de prévenir ces problèmes. Il est important d'intervenir sur ce plan, car la réduction de l'obésité chez les enfants aura probablement des répercussions positives sur leur santé plus tard au cours de leur vie.

6.2 Tabagisme

Même si les taux de tabagisme ont diminué chez les populations autochtones au cours des dernières années, ils sont toujours plus élevés que ceux de la population canadienne en général (Alliance pour la prévention des maladies chroniques au Canada, 2006); (Ritchie et Reading, 2004). Cependant, on se préoccupe beaucoup des taux élevés de tabagisme chez les enfants et les jeunes des populations autochtones (Canada, 2003).

On s'inquiète grandement du tabagisme chez les jeunes Autochtones, car ils fument beaucoup plus que leurs homologues canadiens. Chez les jeunes Canadiens, la prévalence du tabagisme était de 18 % pour les 15 à 19 ans et de 30 % pour les jeunes adultes de 20 à 24 ans, et ces taux étaient plus élevés chez les femmes (2002/2003). En comparaison, la prévalence du tabagisme chez les jeunes Autochtones était de 54 % chez les 15 à 19 ans et de 65 % chez les 20 à 24 ans selon l'Enquête auprès des peuples autochtones (2002/2003). La prévalence du tabagisme était plus élevée chez les jeunes Inuits (73% chez les 15 à 24 ans) que chez les Métis ou les Autochtones (56 % et 59 % respectivement chez les 15 à 24 ans). Ci-dessous, la figure 7 montre les taux de tabagisme pour les différents groupes d'âge et les deux sexes.

Figure 7. Taux de tabagisme à différents âges (n=2,494)



*Percentage for age 12 is suppressed due to small sample size.

Texte du tableau :

Male : Hommes - Female : Femmes

Âge (années)

*Aucun pourcentage n'est inclus pour l'âge de 12 ans, car l'échantillon était trop limité.

Source : Adaptée de l'ERS 2002/2003 (Comité de gouvernance de l'information des Premières nations et coll., 2004)

Les taux élevés de tabagisme chez les adolescents autochtones constituent une source de préoccupation importante pour la santé future des Autochtones, car ces adolescents représentent le plus grand groupe démographique de la population autochtone et ils en sont aussi l'avenir. Les taux particulièrement élevés de tabagisme chez les femmes semblent indiquer qu'il faut cibler ce groupe et comprendre les causes particulières expliquant cette différence entre les sexes.

Non seulement les taux de prévalence sont-ils élevés, mais on constate aussi que les fumeurs autochtones commencent à fumer plus tôt. Selon des parents manitobains interrogés, 19 % de tous les Autochtones de moins de 18 ans fument (Ritchie et Reading, 2004) et c'est surtout à l'âge de 16 ans qu'ils commencent à fumer, nombre d'entre eux commençant dès l'âge de 11 ans. Une enquête réalisée lors des Jeux autochtones de l'Amérique du Nord de 2002 a révélé que l'âge moyen pour commencer à fumer est de 12,2 ans, les plus jeunes commençant à quatre ans (Ritchie and Reading, 2004). À l'âge de 6 ans, environ 2 % des enfants autochtones ont commencé à fumer; le nombre de fumeurs double à l'âge de huit ans, puis double encore à 12 ans et atteint son maximum à 13 ans (Mann et coll., 1992). Dans l'ensemble, les études ont démontré que, de nos jours, les enfants autochtones commencent à fumer lorsqu'ils sont très jeunes.

Comme ces enfants commencent à fumer à un si bas âge, ils accumuleront pendant pratiquement toute leur vie les risques de maladies chroniques découlant du tabagisme et de l'exposition à la fumée secondaire. De nombreuses études ont fait ressortir que le tabagisme aggrave les risques de maladies respiratoires tôt dans la vie, en endommageant le système respiratoire et en favorisant le développement de problèmes respiratoires chroniques (Cunningham, Dockery, Gold, et Speizer, 1995). Tout au long de l'enfance et plus tard dans la vie, l'exposition au tabac peut continuer à réduire le fonctionnement des poumons et augmenter le risque de développer des problèmes pulmonaires (Retnakaran, Hanley, Connelly, Harris, et Zinman, 2005). Les taux de tabagisme constamment élevés chez les jeunes Autochtones sont également inquiétants parce qu'ils risquent de provoquer à long terme des maladies chroniques. Une étude réalisée dans la communauté autochtone de Sandy Lake, où on a constaté que 82 % des participants entre 15 et 19 ans fumaient déjà (Ellickson, 2001), a ainsi démontré l'existence d'un lien étroit entre l'exposition au tabagisme et des facteurs de risque cardiovasculaires, ce qui signifie qu'il faut se préoccuper des répercussions immédiates et à long terme sur cette population.

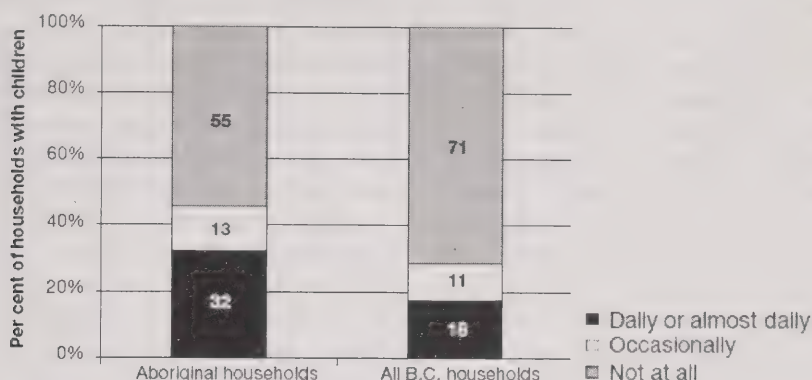
Cependant, les recherches démontrent que la cigarette affecte également la santé mentale. Une étude de suivi longitudinale s'étalant sur cinq ans a révélé un lien statistiquement significatif ($P = 0,05$) entre le tabagisme précoce et les comportements à haut risque chez les adolescents de septième année (Ellickson, 2001) : comparativement aux non-fumeurs, les fumeurs précoces étaient 82 fois plus susceptibles de fumer de la marijuana chaque semaine et 36 fois plus susceptibles de consommer des drogues dures. Ils étaient également 11 fois plus susceptibles de boire de l'alcool chaque semaine, 8 fois plus susceptibles de prendre une cuite et 7 fois plus susceptibles de commettre un vol. Ces adolescents étaient aussi plus susceptibles d'avoir un faible rendement scolaire et des problèmes de comportement à l'école ainsi que de s'adonner à la violence prédatrice et relationnelle (Centre des Premières nations, 2005).

Malgré les statistiques extrêmement négatives dont fait état la littérature sur les jeunes fumeurs autochtones, on compte aussi des statistiques positives sur les habitudes liées au tabagisme chez cette population. Par exemple, l'ERS 2002/2003 a établi que les jeunes Autochtones fumaient

beaucoup moins de cigarettes par jour que les jeunes Canadiens entre la cinquième et la neuvième année (5,9 cigarettes par jour comparativement à 8,1) (Centre des Premières nations, 2005). Une étude transversale réalisée à l'occasion des Jeux autochtones de l'Amérique du Nord de Winnipeg, en 2002, a démontré que la prévalence du tabagisme chez la cohorte étudiée, composée de 570 jeunes Autochtones entre 12 et 22 ans, était de 32 % (Ritchie et Reading, 2004). Une étude de suivi menée lors des Jeux autochtones de l'Amérique du Nord de Cowichan, en 2008, a révélé un taux de tabagisme encore plus bas chez les jeunes Autochtones : à ce moment-là, seulement 6,3 % des jeunes fumaient (Kelly, Link et Reading, 2009). Cette faible prévalence porte à croire que comme les participants à l'étude étaient des spectateurs ou des compétiteurs à une activité sportive, ils avaient peut-être leur santé plus à cœur que les autres jeunes Autochtones et étaient peut-être moins susceptibles d'adopter des comportements nuisibles à la santé (Colombie-Britannique, 2001). Ainsi, une plus grande participation à des activités sportives ou salutaires pour la santé pourrait contribuer à réduire le taux de tabagisme dans les communautés autochtones. Enfin, une réduction de 3 % du taux de tabagisme chez les adultes des Premières nations vivant au Canada de 1997 à 2001 (Comité directeur national de l'Enquête sur la santé des Premières nations et des Inuits, 1999; Centre des Premières nations, 2005) constitue une nouvelle encourageante pour l'avenir. On espère que les taux de tabagisme des adultes continueront de baisser et qu'ils entraîneront aussi une baisse des taux de tabagisme des enfants et des jeunes, grâce à l'exemple donné par les parents. À tout le moins, les enfants et les jeunes des populations autochtones seront moins exposés à la fumée secondaire.

Il est important de prendre en considération les problèmes reliés à la fumée secondaire pour ce groupe d'âge, tout comme pour les nourrissons et les enfants en bas âge (voir les sections sur les facteurs de risque à la naissance et à la petite enfance see natal and early childhood sections en ce qui concerne le « tabagisme des parents »). Selon un sondage sur le tabagisme en Colombie-Britannique réalisé en 1997, 32 % des enfants autochtones étaient exposés quotidiennement ou presque quotidiennement à la fumée de cigarette à la maison comparativement à 18 % pour l'ensemble des enfants de cette province (Colombie-Britannique, 2001). Ci-dessous, la figure 8 résume les données de ce sondage.

Figure 8. Enfants de 11 ans et moins exposés à la fumée secondaire à la maison, Colombie-Britannique, 1997



Source : (Orr et coll., 2001)

Légende de la figure :

Per cent of households with Children: Pourcentage des foyers avec enfants

Aboriginal households : Foyers autochtones

All B.C. households : Tous les foyers de la C.-B.

Daily or almost daily : Quotidiennement ou presque

Occasionally : Occasionnellement

Not at all : Pas du tout

Tel que mentionné auparavant, des taux extrêmement élevés de tabagisme parental ont été relevés dans des études portant sur les Inuits : 48,8 % des ménages comptaient des fumeurs et 36 % des parents avaient l'habitude de fumer à l'intérieur de la maison; seulement 3,4 % des parents affirmaient ne pas fumer (Koch et coll., 2003). Même si la corrélation entre l'exposition à la fumée secondaire et le développement d'une maladie chronique n'est pas établie aussi clairement que dans le cas des comportements liés au tabagisme, on a démontré que l'exposition à la fumée secondaire peut aggraver les problèmes respiratoires et les autres problèmes de santé en plus de favoriser le développement d'un état chronique (Weitzman et coll., 2005). L'incidence inégale qu'a l'exposition à la fumée secondaire sur les maladies chroniques a été démontrée dans une étude portant sur 2273 adolescents américains (Weitzman et coll., 2005). Cette étude examinait précisément le lien entre le tabagisme et le syndrome métabolique. Dans la population étudiée, 5,6 % des adolescents avaient les symptômes du syndrome métabolique. Toutefois, la prévalence du syndrome métabolique était de 1,2 % chez ceux qui n'étaient pas exposés à la fumée secondaire, de 5,4 % chez ceux qui étaient exposés à la fumée secondaire, et de 8,7 % chez les fumeurs (Centre des Premières nations, 2005).

6.3 Santé sexuelle

Selon l'Enquête régionale de la santé de 2002-2003, les jeunes Autochtones sont plus actifs sexuellement que les autres Canadiens du même groupe d'âge (Centre des Premières nations, 2005). Si on tient compte que « l'abus d'alcool et de drogues est [également] plus fréquent chez les jeunes Autochtones que dans la population générale », on peut donc postuler que les jeunes Autochtones pourraient risquer davantage d'avoir des relations sexuelles non protégées et donc d'attraper des maladies transmises sexuellement (MTS) (Gray, 2005). Il existe

aussi un lien entre la santé sexuelle des Autochtones et le développement du cancer. En effet, il a été démontré que les femmes qui ont des relations sexuelles avec plusieurs partenaires ou qui sont sexuellement actives en bas âge sont plus susceptibles de développer le cancer du col de l'utérus (Gray, 2005). Cette relation entre les relations sexuelles précoces et les risques de cancer s'explique par le fait que durant la puberté, les tissus du col de l'utérus subissent de nombreux changements qui pourraient le rendre plus fragile (Gray, 2005). On soupçonne aussi une corrélation entre les MTS et le cancer du col de l'utérus : « L'infection par le virus du papillome humain (VPH) augmente votre risque de 20 à 100 fois » (Gray, 2005). Bien que le VPH soit un virus transmis sexuellement assez répandu, il existe plus de 100 types de VPH et seulement quelques-uns sont à haut risque en ce qui concerne le développement du cancer du col de l'utérus (Gray, 2005; ONSA, 2004; PapScreen Victoria, 2006). Néanmoins, l'activité sexuelle augmente le risque d'être infecté par le VPH et en particulier les types à haut risque de VPH. C'est pourquoi on doit s'inquiéter de ce facteur. Bien qu'on ait démontré que les tests Pap réduisent de façon spectaculaire le nombre de décès découlant d'un cancer du col de l'utérus, le faible taux d'Autochtones qui passent habituellement le test Pap demeure préoccupant pour le dépistage précoce et la guérison de ce cancer dans cette population (Fédération des centres d'amitié indiens de l'Ontario, 2004).

En raison des vulnérabilités particulières des jeunes Autochtones, comme le faible statut socioéconomique, la désillusion découlant des conditions historiques et culturelles ainsi que le manque d'instruction, on s'inquiète également des conséquences de l'exploitation sexuelle de cette population sur sa santé sexuelle et son bien-être. L'Aide à l'enfance Canada – Projet national de consultation des Autochtones a publié récemment un rapport décrivant la nature et l'ampleur de l'exploitation sexuelle des enfants et des jeunes des populations autochtones à des fins commerciales dans l'ensemble du Canada. Cette étude a révélé que :

« Le taux d'exploitation des enfants et des jeunes des populations autochtones à des fins commerciales a atteint plus de 90 % dans certaines communautés où les Autochtones représentent moins de 10 % de la population;

la grave surreprésentation des jeunes Autochtones dans le commerce du sexe est directement liée à la trop forte présence de certains facteurs de risque chez les enfants et les jeunes des populations autochtones, notamment des taux alarmants de pauvreté »
[traduction]

(Fédération des centres d'amitié indiens de l'Ontario, 2004).

Tel que décrit dans ce rapport, ce taux beaucoup trop élevé de jeunes Autochtones pratiquant le commerce du sexe se perpétue en raison des pressions liées à la pauvreté et au faible statut socioéconomique qui sont répandus dans ce groupe (Chansonneuve, 2005; Résolution des questions des pensionnats Indiens Canada, s.d.). En plus des raisons économiques, il faut absolument tenir compte de facteurs culturels et historiques pour comprendre les expériences des enfants et des jeunes. En particulier, on a démontré que les expériences transmises aux enfants par leurs parents ont des répercussions durables sur les pratiques sexuelles des enfants et des jeunes. Les effets précis du système d'éducation d'hier et d'aujourd'hui sur l'histoire qui est apprise et vécue par les enfants et les jeunes des populations autochtones sont traités plus longuement dans la partie qui suit.

6.4 Éducation

Le système d'éducation, passé et présent, fait partie intégrante du vécu des enfants et des jeunes autochtones. En se penchant d'abord sur le passé, la présente section traitera de l'héritage des pensionnats indiens et des répercussions qu'il continue d'avoir sur la santé. On abordera par après le vécu des Autochtones au sein du système scolaire actuel et ses conséquences pour la santé.

6.4.1 Pensionnats indiens

L'éducation des Indiens est devenue une responsabilité du gouvernement fédéral en 1867 avec l'*Acte de l'Amérique du Nord britannique* (Chansonneuve 2005; Fournier et Crey, 1997). À cette époque, des externats indiens avaient déjà été instaurés, mais le rapport Davin de 1879 a pressé le gouvernement d'établir plutôt des pensionnats indiens; Davin croyait que les pensionnats indiens constitueraient le moyen le plus sûr d'assimiler les enfants indiens. En 1892, le gouvernement canadien a mis sur pied des partenariats avec l'Église catholique romaine, l'Église anglicane, l'Église presbytérienne et l'Église méthodiste afin de gérer les activités des pensionnats indiens. Des pensionnats indiens ont été fondés partout au pays, à l'exception des provinces de Terre-Neuve, de l'Île-du-Prince-Édouard et du Nouveau-Brunswick (Fournier et Crey 1997; Résolution des questions des pensionnats indiens Canada [RQPIC], n.d.). Leur fréquentation a augmenté après 1920, lorsqu'un amendement à la *Loi sur les Indiens* a rendu obligatoire pendant 10 mois de l'année l'éducation des enfants indiens de 7 à 15 ans (Fournier et Crey 1997). Dès 1930, près des trois quarts des enfants indiens de tout le Canada fréquentaient un pensionnat indien. Le nombre de pensionnats a atteint un sommet en 1931 alors que plus de quatre-vingt écoles étaient en activité (Résolution des questions des pensionnats indiens Canada [RQPIC], n.d.). Certains enfants autochtones avaient déjà commencé à fréquenter des externats publics sous juridiction provinciale dans les années '50 et, en 1969, lorsque le gouvernement fédéral a pris le plein contrôle des pensionnats indiens, 60 % des étudiants autochtones fréquentaient des externats publics (Fournier et Crey, 1997). De la création des pensionnats indiens au XIX^e siècle jusqu'à la fermeture de la plupart des écoles dans les années '70, près d'un tiers des enfants autochtones ont passé une grande partie de leur jeunesse au pensionnat (Beauchamp et coll., 2004; Chansonneuve, 2005; Résolution des questions des pensionnats indiens Canada [RQPIC], n.d.). La fermeture du dernier pensionnat administré par le gouvernement fédéral a eu lieu en 1996 (Dion, Stout et Harp, 2007). On évalue à 86 000 le nombre d'anciens élèves des pensionnats indiens encore vivants aujourd'hui (Dion, Stout et Kipling, 2003; King, 2006).

Le système des pensionnats indiens n'était pas réservé qu'aux seuls enfants indiens. Les pensionnats, écoles de missionnaire, résidences et pensionnats indiens fréquentés par les enfants inuits sont aussi définis comme faisant partie du système des pensionnats indiens;¹⁰ en outre, les enfants inuits qui vivaient ailleurs qu'à la maison tout en fréquentant un externat fédéral sont aussi considérés comme des élèves des pensionnats indiens (King, 2006). Dans certaines régions du Nord, les églises ont administré des écoles de missionnaire financées par le gouvernement fédéral jusqu'à ce que celui-ci accepte la responsabilité de l'éducation des Inuits (King, 2006). L'éducation dans l'Arctique a été sous le contrôle du gouvernement fédéral de 1955 à 1970. L'inscription des élèves inuits a bondi de 549 au total en 1956 à 2 390 en 1963 (Chansonneuve, 2005). Moins de 15 % des enfants inuits de 6 à 15 ans étaient inscrits dans une école en 1955, mais cette proportion était passée aux trois quarts (75 %) dès 1964.

Des enfants métis ont aussi été élèves dans le système des pensionnats indiens. Le nombre exact des inscrits est difficile à établir car on ne tenait pas toujours des dossiers pour les élèves métis (Chartrand, 2006). Bien que l'éducation des Métis n'ait pas été reconnue comme une responsabilité fédérale, on permettait à l'occasion l'inscription libre ou obligatoire des enfants métis dans les pensionnats indiens dans un but particulier (Chansonneuve, 2005; Chartrand, 2006; Logan, 2001), tel que l'assimilation ou afin de gonfler les chiffres de fréquentation pour augmenter le financement (Chansonneuve, 2005; Logan, 2001). Les facteurs ayant une incidence sur la probabilité de l'admission des Métis dans les pensionnats indiens comprenaient la proximité d'une école avec une communauté, la confession de l'école (les Métis ayant des liens plus étroits avec l'Église catholique romaine), les antécédents familiaux et la position sociale (Logan, 2001). Les enfants métis étaient plus fréquemment admis dans un pensionnat indien si leur famille avait l'argent pour défrayer leurs études, si leurs traits physiques présentaient des attributs indiens ou si leur mode de vie était davantage associé à celui des Indiens et, par conséquent, en plus urgent besoin d'assimilation (Fournier et Crey, 1997; Kirmayer et coll., 2003; Reading, 1999).

Les punitions et les abus étaient répandus et souvent graves dans le système des pensionnats indiens. Les enfants s'exprimant par la langue ou la culture autochtone ou cherchant à communiquer avec leur famille recevaient souvent de dures punitions, que certains chercheurs ont même qualifiées de torture (Chrisjohn et Young, 1995). Ces punitions dépassaient les normes disciplinaires en usage dans les écoles publiques canadiennes à l'époque et les « infractions » qui « justifiaient » ces traitements n'étaient des infractions pour aucun enfant au Canada sauf les Autochtones » (Chansonneuve, 2005). Les abus qui se sont commis dans les pensionnats indiens comprenaient des abus physiques, sexuels, émotionnels et spirituels et ont été décrits comme une violence rituelle ou « des événements traumatisants répétés, systématiques, sadiques et humiliants » (Chansonneuve, 2005; Chrisjohn et Young, 1995; Fournier et Crey, 1997; Kirmayer et coll., 2003; Reading, 1999). Les enfants étaient sous constante surveillance, continuellement sous-alimentés et malnutris, humiliés devant leurs pairs, abaissés en raison de leur culture et de leur héritage autochtone, privés des cadeaux et des lettres de leur famille, coupés de tout réconfort, forcés d'exécuter de durs travaux et obligés d'assister à l'abus d'autres enfants (1997). Fournier et Crey (1997) ont déclaré que les décès d'élèves à la suite d'abus et de négligence

¹⁰ La définition du système des pensionnats indiens au Canada comprend « les écoles de métier, les pensionnats, les résidences pour étudiants, les résidences, le logement chez l'habitant, les pensionnats indiens, les pensionnats indiens comprenant une majorité d'élèves externes ou toute combinaison de ce qui précède ».

avaient été dissimulés, mais que si les écoles étaient tenues responsables, elles seraient coupables de « négligence criminelle, d'homicide involontaire coupable et même de meurtre » ([RQPIC], n.d.; Beauchamp et coll., 2004). Dans les années '90, l'Église catholique, l'Église anglicane, l'Église Unie et l'Église presbytérienne ainsi que le gouvernement canadien ont présenté des excuses pour les abus physiques et sexuels qui se sont commis dans les pensionnats indiens (Corrado et Cohen, 2003; WalDRAM, Herring et Young, 2006). En juin 2008, le gouvernement a finalement présenté des excuses officielles (Harper, 2008).

En plus de subir de multiples abus, les enfants des pensionnats indiens vivaient dans des conditions atroces. Le faible niveau du financement gouvernemental contribuait à la médiocre valeur nutritionnelle de la nourriture et à l'absence de services médicaux pour les élèves (Fournier et Croy, 1997). Les dortoirs des écoles étaient souvent surpeuplés et sans ventilation (Corrado et Cohen, 2003; Fournier et Croy, 1997; WalDRAM et coll., 2006). En raison de ces conditions de vie malsaines, des maladies telles que la tuberculose faisaient rage dans les pensionnats indiens (Chrisjohn et Young, 1995; Fournier et Croy, 1997).

Le fait que l'objectif du système des pensionnats indiens était l'assimilation, plutôt que l'éducation, des enfants indiens est illustré par la médiocre qualité de l'enseignement donné. Seule la moitié de la journée était consacrée au programme académique, et on enseignait aux enfants l'idéologie religieuse le reste du temps ou on les forçait à participer à l'entretien de l'école et à d'autres projets de labeur intensif (Fournier et Croy, 1997). En 1930, à l'apogée du système des pensionnats indiens, les trois quarts (75 %) des élèves indiens n'avaient pas atteint le niveau de la 3^e année (contre moins de la moitié des élèves des écoles publiques provinciales) et seulement 3 % des élèves indiens ont obtenu une scolarité dépassant la 6^e année (contre un tiers des élèves des écoles publiques provinciales) (Reading, 1999). L'enseignement inadéquat dispensé par les pensionnats indiens a inculqué aux anciens élèves peu de compétences pour fonctionner dans la société dominante et pourra avoir nui à leur qualité de vie ultérieure (Chartrand, 2006; King, 2006; Logan, 2001).

L'expérience des enfants métis et inuits ayant fréquenté les pensionnats indiens a été souvent similaire à celles des enfants autochtones. Des anciens élèves métis et inuits des pensionnats indiens ont raconté des histoires de négligence, de conditions de vie malsaines, de punitions brutales, de répression culturelle et d'abus physiques et sexuels (Logan, 2001). Certains élèves métis se sont adaptés plus facilement à la vie des pensionnats indiens en raison de leur plus grande familiarité avec le catholicisme et les langues française et anglaise (Chartrand, 2006; Logan, 2001). D'autres enfants métis ont senti qu'ils étaient traités comme des élèves « de seconde classe » parce que le gouvernement fédéral ne fournissait pas de fonds aux églises pour l'éducation des Métis et qu'il n'étaient perçus ni comme de purs Autochtones avec des droits reconnus, ni comme des blancs de plein droit de la société dominante (Anderson, 2003).

Le système des pensionnats indiens est un chapitre sombre de l'histoire du traitement des Autochtones et de leur éducation par le Canada. Ce qu'il souligne avec une redoutable efficacité, cependant, c'est la grande influence que peut avoir le milieu d'enseignement sur les enfants, les parents, les grands-parents et, bien sûr, les générations futures. En examinant le système d'éducation en vigueur, il sera important de garder à l'esprit l'exemple du système des pensionnats indiens ainsi que les liens étroits qu'entretient l'éducation avec la réussite économique et sociale de tous les Canadiens.

6.4.2 Système d'éducation actuel

En général, les données indiquent que la fréquentation des écoles par les jeunes autochtones est plus faible que celle des non autochtones. Par exemples, les données de 1996 révèlent que « 68 % des jeunes autochtones fréquentaient l'école comparativement à 83 % des jeunes non autochtones » (Statistique Canada, 2001). Elles indiquent aussi que moins d'élèves finissent leurs études : en 1996 également, un peu plus de la moitié (52 %) de la population des Autochtones de 20 à 24 ans vivant hors réserve n'avait pas terminé l'école secondaire. En 2001, cette proportion avait chuté à 48 % (Statistique Canada, 2001). Il existait néanmoins toujours un grand écart entre la population autochtone et la population canadienne en général : en 2001, une proportion de 26 % seulement de la tranche des 20 à 24 ans de la population générale n'avait pas terminé l'école secondaire (Statistique Canada, 2001).

La proportion de diplômés de l'école secondaire est un indicateur prévisionnel important des futurs taux de scolarité et d'emploi. On retrouve certains renseignements importants sur les taux d'inscription et d'achèvement des études postsecondaires des Autochtones dans un rapport de 2004 de la Fondation canadienne des bourses d'études du millénaire intitulé *La population autochtone et l'éducation postsecondaire : ce que les enseignants ont appris*. Les paragraphes suivants examinent certaines de ses principales conclusions.

Comme le fait remarquer la Fondation canadienne des bourses d'études du millénaire, les taux d'inscription et d'achèvement des études postsecondaires des Autochtones ont augmenté avec régularité au cours des deux dernières décennies. Malgré ces hausses, toutefois, les taux des Autochtones demeurent considérablement plus faibles que ceux des Canadiens non autochtones (Malatest, 2004). Par exemple, le recensement de 1996 a révélé ce qui suit :

« Trois pour cent des Indiens inscrits (c.-à-d. de plein droit) et quatre pour cent des membres d'autres groupes d'identité autochtone avaient obtenu des diplômes universitaires, comparativement à 14 % chez tous les autres Canadiens. Le pourcentage d'Indiens inscrits ayant fait des études postsecondaires s'élevait à 37 %, alors qu'il était de 47 % chez tous les autres groupes d'identité autochtone, des taux sensiblement inférieurs à celui relevé chez tous les autres Canadiens, soit 51 % » (Malatest, 2004).

Bien que l'augmentation du nombre des diplômés autochtones soit encourageante, il est important de se rappeler qu'il existe encore bien des limites et des obstacles à la réussite scolaire des jeunes autochtones. La citation suivante précise certaines de ces limites et barrières :

« Défavorisés dès le départ en raison de problèmes socioéconomiques (pauvreté, chômage, etc.), (les élèves autochtones) doivent également surmonter des barrières moins tangibles, comme la discrimination, le faible estime de soi et le manque de sensibilité des établissements à l'égard de leur culture. Plusieurs entreprennent des études collégiales ou universitaires sans formation adéquate; d'autres essaient tant bien que mal de conjuguer études et responsabilités familiales. Ajoutons à cela le rôle des établissements dans l'assimilation des autochtones et le constat est clair : dans leur cas, les obstacles à l'éducation postsecondaire sont énormes (Malatest, 2004).

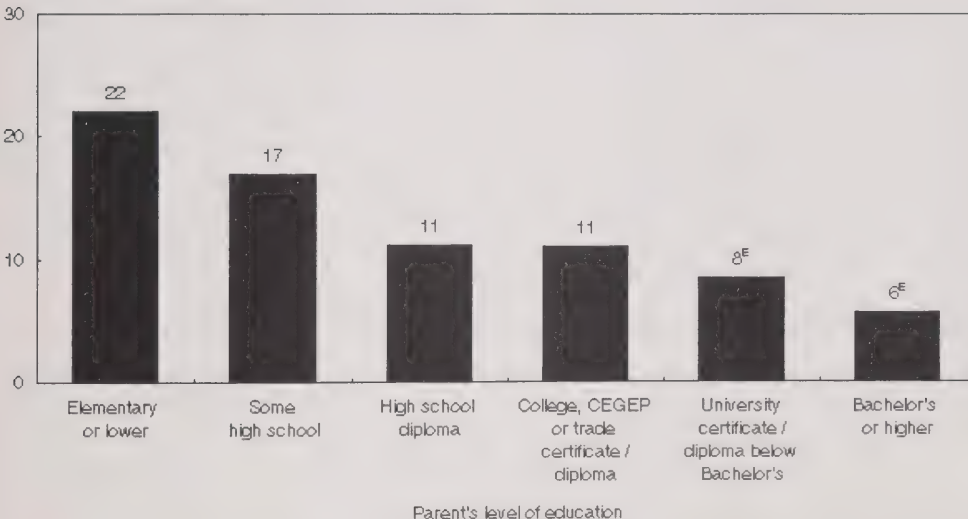
L'enseignement postsecondaire doit donc tenir compte des besoins sociaux, culturels et économiques des Autochtones (Malatest, 2004).

Il est essentiel de tenir compte de ces difficultés et de ces obstacles, ainsi que des données brutes relatives à l'éducation des Autochtones, car l'importance et la valeur d'une formation académique secondaire et postsecondaire ne font qu'augmenter avec le temps : « Avec l'émergence d'une économie du savoir, les emplois se raréfient de plus en plus pour les personnes sans diplôme d'une école secondaire, d'un collège ou d'une université » (Statistique Canada, 2001). Statistique Canada (2001) a constaté qu'il était possible d'attribuer en partie les écarts du taux de chômage chez les Autochtones à la formation scolaire. Cela signifie que la scolarité peut prédire l'employabilité d'une personne et, par conséquent, sa situation socioéconomique future.

Les recherches ont aussi constaté que le taux de scolarisation parmi les enfants et les jeunes autochtones est étroitement lié au niveau de scolarité de leurs parents (Statistique Canada, 2001). Par exemple, De Broucker et Lavallée (1998) ont signalé que plus le niveau de scolarité des parents était élevé, plus élevé était celui de leurs enfants. Cette association est illustrée par le diagramme suivant, qui montre que l'éducation des parents est un facteur de la probabilité qu'un enfant autochtone redouble une année.

Figure 9. Pourcentage d'enfants autochtones hors réserve ayant redoublé une année

Percent who repeated a grade



Source: Statistics Canada, *Aboriginal Peoples Survey*, 2001.

Pourcent

age ayant redoublé une année

Primaire ou moins	Études secondaires	Diplôme d'études secondaires	Certificat/diplôme d'un collège, d'un CEGEP, d'une école professionnelle Niveau de scolarité parental	Certificat/diplôme universitaire inférieur au baccalauréat	Baccalauréat ou plus
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Source : Statistique Canada, Enquête auprès des peuples autochtones de 2001.

Le diagramme montre que, à mesure que le niveau de scolarité des parents augmente, la proportion d'enfants ayant redoublé une année diminue. C'est-à-dire que, dans le cas de parents n'ayant pas été plus loin que l'école élémentaire, 1/5^e des enfants avaient redoublé une année alors que seulement 6 % des enfants de parents ayant un diplôme de baccalauréat ou davantage avaient redoublé une année à un moment de leur vie. Voici certaines des raisons avancées pour expliquer cette corrélation entre la scolarité des parents et celles des enfants : 1) les parents ayant atteint un plus haut niveau de scolarité s'intéresseront davantage à l'éducation de leur enfant et encourageront les activités d'apprentissage et les devoirs (Stevenson et Baker, 1987) et 2) les parents très scolarisés ont tendance à avoir des attentes académiques plus élevées à l'endroit de leurs enfants, ce qui s'est avéré avoir une grande influence sur la réussite d'un enfant à l'école (Astone et McClanahan, 1991; Hull Research Analysis et MAINC, 2000; Teachman, 1987; Teachman et Paasch, 1998). Outre les influences parentales, la famille élargie, les Anciens et la communauté jouent un rôle essentiel dans l'éducation et l'apprentissage des enfants au sein des populations autochtones. Cela est dû au fait que l'éducation au sein des communautés autochtones couvre à la fois le développement cognitif et l'apprentissage de la manière de se comporter en société (Smith et coll., 1997). Cela indique que le niveau de scolarité et l'appui manifesté par la communauté et la famille élargie sont capitaux pour la croissance et le développement de l'enfant.

En plus du niveau de scolarité et de l'appui parentaux et familiaux, la réussite des enfants à l'école a aussi été liée au revenu de la maisonnée. De fait, plusieurs études ont montré que les enfants des familles économiquement défavorisées éprouvent de plus grandes difficultés d'apprentissage et ont davantage de problèmes à l'école (Chao et Willms, 2002; Duncan et Brooks-Gunn, 1997; Petterson et Albers, 2001; Ross et Roberts, 2000; Smith et Klebanov, 1997; Statistiques Canada, 2001). Les statistiques du taux de scolarité des enfants autochtones vivant hors réserve confirment cette constatation : « Environ 16 % des enfants des familles ayant un revenu sous le seuil de faible revenu ont redoublé une année d'école à un moment, comparativement à seulement 10 % des enfants des familles se trouvant au seuil du faible revenu ou au-dessus » (Bennett, Blackstock et De La Ronde, 2005; Canada, 2006; Fournier et Crey, 1997; Gough, Trocmé, Brown, Knoke et Blackstock, 2005; Kirmayer et coll., 2003; Sinclair, 2007).

6.5 Placement en famille d'accueil, tutelle et services à l'enfance autochtone

Au cours des années '60, alors que les enfants autochtones s'inscrivaient en nombre croissant dans les écoles publiques provinciales plutôt que dans les pensionnats indiens financés par le gouvernement fédéral, un nouvel assaut contre les familles autochtones s'est dessiné. Surnommé la « Sixties Scoop » (rafle des années '60), cet assaut s'est manifesté par l'enlèvement d'un nombre disproportionné d'enfants autochtones de leurs familles et de leur communautés pour les placer en famille d'accueil (Fournier et Crey, 1997). Les enfants autochtones, qui représentaient moins de 4 % de la population canadienne et 1 % seulement des enfants pris en charge en 1959, constituaient soudainement de 30 à 40 % des enfants pris en charge à la fin des années '60 (Fournier et Crey, 1997; Sinclair, 2007). Plus souvent qu'autrement, les enfants autochtones retirés de leur famille étaient placés dans des foyers non autochtones (1996). La Commission royale sur les peuples autochtones (Fournier et Crey, 1997; Gough et coll., 2005) a signalé que, sauf dans le cas du Québec, la proportion des enfants autochtones pris en charge placés dans des foyers non autochtones oscillait entre 70 et 90 % d'une province à l'autre. À l'image de ce

qu'avaient vécu les enfants ayant fréquenté les pensionnats indiens, les enfants autochtones placés sous tutelle étaient séparés de leurs parents, de leurs frères et sœurs, de leur communauté et de leur identité culturelle, souvent sans savoir d'où ils venaient et parfois sans même conserver leur prénom natal (Bennett et coll., 2005). Les enfants d'une même famille étaient souvent placés dans des foyers séparés, en partie en raison de la difficulté de trouver des foyers pouvant accueillir les grosses familles autochtones, mais aussi dans le but d'assimiler plus complètement les enfants. Peu d'enfants sont revenus dans leur famille d'origine (Fournier et Crey, 1997).

Motivée par la même attitude paternaliste ayant créé le système des pensionnats indiens, la « Sixties Scoop » a été nourrie par la croyance que les parents autochtones étaient incapables d'élever leurs enfants (Canada, 2006). Les médiocres compétences parentales acquises par les générations d'enfants autochtones ayant fréquenté les pensionnats indiens ont probablement contribué à cette croyance (Bennett et coll., 2005; Fournier et Crey, 1997). Cependant, bon nombre d'enfants ont été retirés de leur famille pour des raisons sur lesquelles les parents autochtones avaient peu de contrôle, c'est-à-dire une mauvaise situation socio-économique ou simplement le fait d'être autochtone (Morris, 2007). Les travailleurs sociaux, formés à l'application de normes eurocentristes dans les services d'aide à l'enfance, croyaient qu'il était du meilleur intérêt des enfants de les retirer des réserves frappées par la pauvreté plutôt que de fournir des services de soutien aux familles et aux communautés dans le besoin (Fournier et Crey, 1997; Kirmayer et coll., 2003).

Bien qu'on ait appelé « Sixties Scoop » ce processus d'enlèvement des enfants autochtones de leurs foyers, les organismes de protection de la jeunesse ont continué de soustraire les enfants autochtones de leurs foyers bien après les années '60 (Fournier et Crey, 1997). À la fin des années '70, au moins un enfant autochtone sur trois avait été pris en charge par les services gouvernementaux (Bennett et coll., 2005). En 1983, les enfants autochtones constituaient à peu près 50 % des enfants pris en charge en Alberta, 60 % au Manitoba et 70 % en Saskatchewan (Blackstock, Trocmé et Bennett, 2004; Kirmayer et coll., 2003). Aujourd'hui, la présence disproportionnée des enfants autochtones dans les services de placement se perpétue (Sinclair, 2007) et un professeur d'université a suggéré que la « Sixties Scoop » s'était transformée en « Millennium Scoop » (rafle du Millénaire) (2004). Blackstock et ses collègues (1997) estiment qu'il y a aujourd'hui, en comparaison avec le nombre d'enfants autochtones fréquentant les pensionnats indiens au cours de leurs années d'apogée, trois fois plus d'enfants autochtones en placement. Fournier et Crey (1997) signalent qu'en Colombie-Britannique, plus de la moitié (52 %) des enfants placés par ordonnance du tribunal chaque année sont Autochtones. Plus des trois quarts (78 %) des enfants autochtones en placement permanent en Colombie-Britannique sont placés dans des foyers non autochtones (Sinclair 2007).

Les conséquences pour les enfants autochtones élevés dans des foyers non autochtones ne sont pas toujours néfastes; en grandissant, certains de ces enfants ont trouvé le succès et le bonheur dans leur carrière, leur famille et leur communauté (Bennett et coll., 2005; Carriere, 2007; Sinclair, 2007). Cependant, bon nombre d'Autochtones étant passés par le système des services d'aide à l'enfance ont raconté l'histoire de leur combat pour se constituer une identité à travers leur famille d'accueil, leur famille adoptive, leur famille biologique, la communauté autochtone et la société dominante (Bennett et coll., 2005; Morris, 2007; Sinclair, 2007). Ces combats ont été ardues tout au long de leur enfance et de leur adolescence, et parfois même dans leur vie adulte. Les conséquences néfastes pour la santé mentale des enfants autochtones placés dans des

foyers non autochtones peuvent comprendre des problèmes d'affirmation de l'identité, une faible estime de soi, un sentiment de honte, des idées et des tentatives de suicide, l'abus d'intoxicants, l'itinérance et l'incarcération (Anderson, 2003). Ces questions de santé mentale se posent en problèmes non seulement pour la cohorte des Autochtones maintenant adultes ayant subi la « Sixties Scoop », mais constituent dans un proche avenir des problèmes de santé potentiels pour le nombre disproportionné d'enfants autochtones se trouvant encore dans le système des services d'aide à l'enfance.

Une analyse des données relatives aux enfants pris en charge de trois provinces d'échantillonnage en mai 2005 a révélé qu'un enfant sur dix, parmi tous les enfants des Indiens inscrits membres des Premières nations, était pris en charge par les services à l'enfance, comparativement à un enfant non autochtone sur 200 (Blackstock, Prakash, Loxley et Wien, 2005). Les données de fin d'exercice recueillies par le ministère des Affaires indiennes et du Nord indiquent que le nombre des enfants d'Indiens inscrits membres des Premières nations vivant dans les réserves pris en charge par les services à l'enfance a augmenté d'un stupéfiant 71,5 % entre 1995 et 2001 (McKenzie 2002). L'Étude canadienne sur l'incidence des signalements de cas de violence et de négligence envers les enfants (Trocmé, MacLaurin, Fallon, Daciuk, Billingsley et coll., 2001) a constaté que la négligence était la principale raison pour laquelle les enfants des Premières nations étaient confiés aux services à l'enfance de façon aussi disproportionnée. La vérification des paramètres de pauvreté, de consommation d'intoxicants et d'insalubrité des logements a expliqué en grande partie cette surreprésentation (Trocmé, Knoke et Blackstock, 2004; Trocmé, MacLaurin, Fallon, Knoke et coll., 2006).

La surreprésentation des enfants des Premières nations se produit à chaque étape de l'intervention des services à l'enfance, à partir du signalement, de l'enquête et de la corroboration jusqu'à la prise en charge et au placement permanent par les services de protection de l'enfance (Trocmé, MacLaurin, Fallon, Knoke et coll., 2006; Blackstock, 2007). L'analyse préliminaire des données sur les enfants pris en charge de trois provinces [1] et de 27 organismes de services à la famille et à l'enfance des Premières nations fait aussi état d'un nombre disproportionné de placements permanents au Canada (Société de soutien à l'enfance et à la famille des Premières nations du Canada, 2006). Par exemple, au mois de mai 2005, les enfants autochtones constituaient 7,3 % de la population des enfants de la province de la Colombie-Britannique (Statistique Canada, 2001), mais 47,8 % de tous les enfants pris en charge (British Columbia Ministry for Children and Family Development, 2005). En Nouvelle-Écosse, les enfants des Premières nations sont de trois à six fois plus susceptibles d'être confiés aux services d'aide à l'enfance que les enfants non autochtones (Nova Scotia Department of Community Services, 2008). En outre, les enfants autochtones constituaient 53,5 % de tous les enfants en placement permanent en C.-B. et 47,6 % de tous les enfants en placement temporaire (British Columbia Ministry for Children and Family Development, 2005). En 2005, une enquête auprès de 27 organismes de services à la famille et à l'enfance des Premières nations dans tout le Canada (sauf l'Ontario) a constaté que 47 % des enfants desservis étaient en placement permanent (Société de soutien à l'enfance et à la famille des Premières nations du Canada, 2006).

La pauvreté est un facteur de risque général nuisant au bien-être spirituel, émotionnel, cognitif et physique des enfants, des familles et des communautés (Loppie-Reading et Wien, 2009). Par exemple, les recherches ont indiqué avec constance que les enfants vivant dans la pauvreté

présentent des insuffisances du développement physique et mental et réussissent moins bien à l'école (Gabrarino, 1995; Blackstock, Bruyere et Moreau, 2007; Barth, 2006; Loppie-Reading et Wien, 2009), ce qui a un lien particulier avec la corroboration des cas de négligence (Sealand, 2003; Lindsey, 2004; Trocmé et coll., 2006). Bien qu'il serait déraisonnable de s'attendre à ce que les services d'aide à l'enfance puissent éradiquer la pauvreté à eux seuls, l'attente minimale à l'égard des services d'aide à l'enfance est qu'ils centrent leur discours sur cet aspect, étant donné l'omniprésence des preuves de ses conséquences pour la sécurité et le bien être de l'enfant.

Pour les services d'aide à l'enfance, la pauvreté peut se manifester par de la négligence physique ou l'omission de superviser et constituer un facteur aggravant d'autres formes de maltraitance (Lindsey, 2004; Trocmé et coll., 2006). La législation provinciale en matière de protection de la jeunesse, y compris la *Child and Family Services Act* de Nouvelle-Écosse, ne fait pas de distinction entre la négligence résultant de la pauvreté et celle découlant de l'insouciance des parents. Il s'agit d'une question cruciale au sein des communautés des Premières nations chez qui la pauvreté est plus répandue, et plus profonde, que parmi les Canadiens non autochtones.

7. Facteurs de risque chez les adultes et les aînés

Tel que mentionné dans les sections précédentes, la population autochtone du Canada est plus jeune que la population générale : « L'âge médian de la population autochtone du Canada était de 24,7 ans en 2001, comparativement à 37,7 ans pour la population non autochtone du Canada » (Canada, 2003). Mais, bien que la génération adulte ne domine pas la population autant que le fait la génération des enfants du baby boom au sein de la population non autochtone du Canada, leurs besoins et leurs inquiétudes en matière de santé sont d'importance égale. En outre, comme l'espérance de vie des autochtones continue d'augmenter et que les maladies chroniques commencent à prendre le pas sur les maladies transmissibles, la santé et le bien être des adultes et des aînés joueront un rôle encore plus important dans le profil de la santé autochtone. En gardant cela à l'esprit, les facteurs de risque particuliers associés aux maladies chroniques chez les Autochtones adultes, tel que l'usage du tabac, l'abus d'alcool, l'obésité, l'emploi et l'éducation sont abordés ci-après. Enfin, on traitera des aspects particuliers de la santé des aînés à la fin de la présente section.

7.1 Usage du tabac

Tel que mentionné dans les sections traitant du tabagisme maternel et parental et de l'usage du tabac chez les enfants et les jeunes autochtones, le taux de tabagisme dans la population autochtone est plus élevé que dans la population non autochtone. En fait, la population autochtone du Canada connaît une proportion beaucoup plus élevée de fumeurs actifs (58 % c. 31 %), et moins d'anciens fumeurs (17 % c. 23 %) ou de personnes n'ayant jamais fumé (24 % c. 45 %) que la population générale. Selon le Rapport d'étape 2005 sur la lutte contre le tabagisme de Santé Canada, presque 60 % des adultes des Premières nations de 18 à 34 ans vivant dans les réserves fument. Cela peut se comparer aux données de l'Enquête de surveillance de l'usage du tabac au Canada (ESUTC), qui indiquaient que la population générale du Canada comptait 21 % de fumeurs en 2003 (Canada, 2005). Les taux d'usage du tabac sont encore plus élevés parmi les Inuits du nord du Canada, chez qui presque 70 % de la population adulte fume du tabac (Canada, 2005). L'Enquête régionale sur la santé de 2002-2003 a documenté des taux de tabagisme similaires (58,8 %) chez les adultes des Premières nations (First Nations Centre, 2005).

Il est important de compléter ces statistiques par un exposé sur les risques de développement de maladies chroniques associées à l'usage du tabac. Par exemple, on a estimé que le tabagisme est à l'origine d'environ un tiers de tous les cancers mortels (Greenhalgh, 1981; Haustein, 2003; Swales et De Bono, 1993). La relation entre le taux de tabagisme et le taux de cancer a été établie par la communauté des chercheurs, qui a constaté qu'elle était directement proportionnelle; en d'autres termes, plus élevé est le taux de tabagisme, plus élevé est le taux de cancer. Cela est préoccupant en ce qui concerne le taux de cancer chez les Autochtones, les statistiques ayant déjà commencé à enregistrer une hausse du taux de cancers antérieurement inexistantes chez les populations autochtones. L'usage du tabac a été associé à une augmentation du risque des maladie cardiovasculaires et du diabète (Sin et coll., 2002) ainsi qu'à des taux d'incidence et de prévalence plus élevés des maladies pulmonaires obstructives chroniques et de l'asthme (Ghadirian, 2005)

La bonne nouvelle est que l'abandon du tabac à n'importe quel stade de la vie peut diminuer de façon importante les risques associés au tabagisme. Comme le précise Ghadirian (2005), l'abandon du tabac peut diminuer grandement les risques de maladies cardiovasculaires : moins d'un an après l'abandon, le risque de maladie du cœur de l'ancien fumeur a déjà diminué de près de 50 % par rapport au fumeur encore actif (Ghadirian, 2005). Une étude menée chez des hommes de moins de 55 ans a révélé que, bien que le risque ne soit pas significativement différent chez ceux ayant abandonné le tabac au cours de la dernière année, il chutait au bout de deux presque au niveau de celui des non fumeurs (Ghadirian, 2005). Le risque résiduel de maladies cardiovasculaires après avoir cessé de fumer dépend fortement de l'exposition cumulative antérieure à la fumée de cigarette, de la durée écoulée depuis l'arrêt et de l'état de santé de la personne au moment de l'abandon du tabac. Cependant, après 10 ou 15 ans sans tabac, l'état de santé de la plupart des anciens fumeurs n'est pas significativement différent de celui d'une personne n'ayant jamais fumé (Stephens et Santé Canada, 1999). Cela signifie que les stratégies ciblées d'abandon du tabac ont le potentiel d'abaisser le taux de risque de maladies et de favoriser une meilleure santé à l'avenir (Tjepkema, 2002).

7.2 Abus d'alcool

Selon l'Institut national du cancer du Canada, on définit l'usage excessif d'alcool comme l'ingestion de cinq consommations ou plus en une seule occasion. On a constaté que la prévalence de la consommation abusive d'alcool était plus élevée au sein des communautés des Premières nations (16 %) que dans la population canadienne générale (6,2 %). La population autochtone hors réserve est moins susceptible que la population générale du Canada de consommer régulièrement (c.-à-d., toutes les semaines), mais plus susceptible d'enregistrer un taux plus élevé de consommation abusive d'alcool (Institut national du cancer, 2002). Par conséquent, les risques que fait courir à la santé la consommation abusive d'alcool constituent une grave préoccupation pour la population autochtone du Canada.

On a signalé que la consommation abusive d'alcool augmentait le risque de développement de cancers. On a constaté en particulier que des niveaux de consommation élevés augmentaient le risque de cancer du foie et de cancer colorectal. Le fait de prendre une seule consommation par jour pour les femmes ou deux consommations par jour pour les hommes a été associé à l'augmentation du risque du cancer de la bouche, du larynx, du pharynx, de l'œsophage et du foie. En outre, les femmes prenant deux consommations par jour augmentent de 25 % le risque

de contracter un cancer du sein comparativement aux femmes ne buvant pas d'alcool (Institut national du cancer, 2002). Enfin, la combinaison de la consommation d'alcool et de l'usage du tabac augmente considérablement le risque de cancer du poumon.

Tel que mentionné précédemment, l'abus d'alcool peut constituer une condition chronique en soi. Son association fréquente à la dépression, aux expériences antérieures, aux traumatismes et à d'autres souvenirs ou situations présentes désagréables, illustre le fait que l'alcoolisme a un effet profond sur la santé et l'aptitude à fonctionner dans le monde environnant. Donc, l'alcool peut non seulement avoir une influence et présenter le risque de devenir une condition chronique, mais a aussi le statut potentiel, en tant que condition chronique, de générer des difficultés permanentes et des problèmes supplémentaires pour l'utilisateur. Il faut prendre très au sérieux les risques physiques et psycho-sociaux associés à l'alcoolisme tant au sein des communautés autochtones que non autochtones.

7.3 Obésité et inactivité

L'obésité est un facteur de risque important pour bon nombre de maladies chroniques. L'obésité se mesure souvent par la mesure du poids ou l'indice de masse corporelle (IMC), qui produit une mesure en fonction de la taille et du poids de la personne. Les pourcentages de personnes possédant un indice de masse corporelle normal, plus élevé ou plus bas au sein des populations autochtone et non autochtone du Canada, selon le rapport de 2002-2003 de l'Enquête régionale sur la santé (ERS), sont reprises dans le tableau ci-après.

	Adultes des Premières nations	Adultes canadiens
Poids normal	25,9 %	49 %
Préobèse	37,0 %	33 %
Obèse	31,2 %	15 %

Source : Centre des Premières nations, 2005

Tel que le précise aussi le rapport 2002-2003 de l'ERS, la répartition de l'obésité au sein de la population autochtone est influencée par le sexe (First Nations Centre, 2005). Par exemple, on a constaté que les hommes étaient surreprésentés dans le groupe des préobèses alors que les femmes autochtones étaient plus susceptibles d'être obèses ou obèses morbides (MacMillan et coll., 1996). Il est important de souligner ici que des préoccupations ont été exprimées relativement à la mesure de l'obésité chez certains groupes autochtones, comme les Inuits. Tel qu'on l'a montré chez de jeunes enfants de l'Arctique, différents cycles de croissance et différents gradients de taille à poids, qui demeurent jusqu'à la maturité, peuvent donner une mesure d'obésité alors que celle-ci n'existe pas (Comité national directeur de l'Enquête régionale sur la santé des Premières Nations et des Inuits, 1999). L'Enquête régionale sur la santé des Premières Nations et des Inuits de 1999 (Comité national directeur de l'Enquête régionale sur la santé des Premières Nations et des Inuits, 1999) a constaté que 36 % des femmes inuits du Labrador et 26 % des hommes inuits du Labrador sont préobèses (McIntyre et Shah, 1986). La prévalence de l'obésité au sein de la population autochtone du nord de l'Ontario va de 50 % à 70 % chez les femmes autochtones et de 30 % à 50 % chez les hommes autochtones (Young et Sevenhuysen, 1989). Une étude menée au sein d'une population Ojibwa et Cri a révélé que dans

certain groupe d'âge et selon le sexe, presque 90 % des personnes étudiées étaient préobèses et obèses (Tjepkema, 2002). En outre, il semble que la différence de niveau d'activité physique entre la population autochtone hors réserve et la population non autochtone du Canada habitant les provinces soit minime. Dans les territoires, cependant, la population autochtone était moins susceptible d'être active que les autres habitants du Nord (Denny, 2005).

L'inactivité est un facteur contributif clé de l'obésité au sein des populations autochtone et non autochtone. Malheureusement, on a constaté des taux d'inactivité élevés au sein de bon nombre de communautés autochtones. Une étude menée aux É.-U. en 2001 et 2002 et portant sur les facteurs de risque de maladie chronique des Inuits et des Autochtones américains a constaté que 37,2 % de ceux-ci ne s'adonnaient à aucune activité physique pendant leurs loisirs. L'enquête a aussi révélé que 29,3 % des sujets étaient obèses (rapport de cotes = 1,41) (First Nations Centre, 2005). On a aussi signalé une telle inactivité au sein de la population des Premières nations. En raison de la disparition des terres et des pratiques ancestrales des Premières nations, tel que la chasse, la trappe et la pêche, une proportion plus élevée des Autochtones a commencé à adopter un mode de vie plus sédentaire. À cela s'est ajoutée l'adoption par les Premières nations d'un régime non traditionnel (ou communément appelée « occidentale »¹¹) après la colonisation. À la suite de ces changements et d'autres changements socio-économiques, le pourcentage de personnes inactives et obèses a augmenté au sein des communautés des Premières nations (Canada, 2001). Malgré le fait que la proportion des personnes inactives et obèses est en hausse, on peut contrer cela par la sensibilisation à l'importance de l'exercice et la promotion d'une vie active. Cibler ainsi des stratégies d'intervention et des traitements constructifs a le potentiel d'améliorer la santé dans l'avenir.

7.4 Emploi et scolarité

Du fait que l'âge moyen de la population autochtone est de 10 ans plus jeune que celui de la population générale, il se produira une forte augmentation de la population des autochtones en âge de travailler (25 à 44 ans) au cours de la prochaine décennie (Malatest, 2004). Et, bien que le niveau de scolarité de ce groupe d'âge se soit amélioré de 14 % au cours de la décennie – une augmentation supérieure à l'amélioration de 10 % enregistrée au sein de la population non autochtone –, l'écart entre les deux groupes reste considérable (Malatest, 2004). Par exemple, la proportion d'Autochtones dans la vingtaine possédant un diplôme d'études postsecondaires est passée de 19 % à 23 % entre 1981 et 1996, mais la proportion de ceux possédant un diplôme ou un certificat universitaire n'a pas bougé de façon significative (de 3 % à 4 %). Plus encore, le niveau de scolarité des Canadiens autochtones reste sous la moyenne nationale; en 1996, 54 % des Autochtones de 15 ans et plus n'avaient pas de diplôme d'études secondaires, contre 35 % de la population non autochtone (Anderson, 2003). Le niveau de scolarité et le taux d'emploi sont étroitement associés (Tjepkema, 2002) :

En 2000-2001, la population autochtone hors réserve, dans son ensemble et dans diverses régions du pays, avait atteint un niveau de scolarité et un revenu par ménage inférieur et était moins susceptible d'avoir travaillé toute l'année que la population non autochtone (Statistique Canada, 2001).

¹¹ Une diète occidentale est d'ordinaire riche en gras et en protéines et faible en fibres.

Selon le recensement de 2001, le taux de chômage des adultes autochtones de 25 à 34 ans possédant un diplôme universitaire était de 8 % alors que celui de ceux ayant terminé une 9^e année, mais pas leurs études secondaires, était de 28 %. Chez ceux n'ayant pas terminé une 9^e année, le taux de chômage était de 40 % (Statistique Canada, 2001). Les chercheurs ont aussi constaté que l'obtention d'une scolarité postsecondaire avait une certaine incidence favorable sur l'emploi et le revenu des Autochtones (Hull et coll., 2000; Maxim, White, Whitehead et Beavon, 2000).

Les statistiques sur le chômage des Autochtones soulignent l'envergure de cet important problème : en 1998, le taux de chômage moyen dans les réserves autochtones était de 29 %, ce qui est presque le triple du taux national (Canada, 2001; Canada, Parlement, Chambre des communes, Comité permanent de la santé, 1995). La situation était encore pire dans certaines communautés, où on signalait des taux de chômage atteignant 90 % (MacMillan et coll., 1996). Bien qu'on trouve certains des taux les plus élevés dans les réserves, on pense qu'en moyenne 25 % des adultes autochtones (15 ans et plus) étaient au chômage en 1996, contre tout juste moins de 10 % de la population générale (Canada, 2001). La disparité dans l'emploi et ses liens avec la pauvreté sont illustrés par le fait que, en 1995, le revenu moyen d'emploi des Autochtones était de 17 382 \$, ce qui est environ les deux tiers de la moyenne nationale de 26 474 \$ (MacMillan et coll., 1996). En 1990, plus de la moitié (54 %) des adultes autochtones ont déclaré un revenu annuel de moins de 10 000 \$, alors que seulement 35 % des Canadiens ont déclaré un revenu du même niveau (First Nations Centre, 2005; Oberle et MAINC, 1993). Les plus récentes données ont fait état d'une certaine amélioration des taux d'emploi chez les Premières nations vivant au Canada : l'ERS de 2002-2003 a révélé que 33,2 % des adultes des Premières nations ont déclaré un revenu de moins de 10 000 \$ et que le taux d'emploi enregistré chez les populations des Premières nations était inférieur de 8 % à celui de la population canadienne en 2001 (First Nations Centre, 2005; Mendelson, 2004). D'autres données récentes ont indiqué une amélioration de 5 à 7 % des taux d'emploi entre 1991 et 2000 et l'égalisation des taux d'emploi chez les Autochtones vivant dans les réserves et hors réserve (Green et coll., 2003).

Bien que ces statistiques dressent un tableau de vulnérabilité de l'environnement socio-économique des Autochtones au Canada, il est important de souligner ici que, bien que la scolarité et l'emploi aient une incidence directe sur la situation socio-économique de tout un chacun, ils ont aussi des conséquences particulières pour la santé et le bien-être de l'individu. De fait, on a constaté que la scolarité et l'emploi peuvent être des prédictors clés de l'apparition de maladies chroniques et de la survie. On a associé, par exemple, un taux de survie plus faible au cancer à un bas niveau de revenu et un taux de chômage élevé (Ward et coll., 2004). Une étude de 2003 a relevé une concentration substantielle de cas de diabète dans les zones de Winnipeg à la situation socio-économique défavorisée, à la qualité de l'environnement médiocre, aux modes de vie malsains et à forte concentration d'Autochtones (Green et coll., 2003). L'étude a aussi constaté que la scolarité et le revenu étaient des prédictors plus robustes du diabète que le statut d'Autochtone, suggérant que c'est la situation socio-économique plutôt que des facteurs génétiques qui étaient responsables de la forte prévalence du diabète (Santé Canada, 2005).

7.5 Santé des aînés

Au Canada, l'espérance de vie à la naissance pour la population des « Indiens inscrits » demeure moindre que celle de la population canadienne générale : 68,9 ans chez les hommes et 76,6 ans pour les femmes en 2000, une différence de 7,4 ans entre les hommes autochtones et non autochtones et de 5,2 ans entre les femmes autochtones et non autochtones (Durie, 2004). Non seulement la population des aînés est-elle plus clairsemée, mais les aînés sont généralement plus jeunes au sein des communautés autochtones que dans les communautés non autochtones. Bien sûr, il faut faire la distinction entre les aînés en raison de l'âge et ceux qui sont considérés comme des « Anciens » dans leur communauté en raison de la force et de la sagesse dont ils font preuve. Bien qu'un âge avancé concorde souvent avec le statut d'Ancien, l'expérience, le savoir et la sagesse détenus par la personne comptent bien davantage. On abordera dans la présente section la santé des aînés et des anciens dans les populations autochtones en tant que tranche la plus âgée de ces populations.

C'est sans surprise que les risques attribués à la santé des aînés sont largement associés à l'âge. Pourtant, du fait de l'espérance de vie généralement moins longue et d'une population plus jeune, la littérature n'a pas exploré avec vigueur la santé de la population autochtone plus âgée et les risques associés au troisième âge et aux maladies chroniques. Ce que la littérature canadienne a relevé, c'est qu'un autochtone des États-Unis sur trois vit sous le seuil de la pauvreté (Cueller, 1990). Cela signifie que bon nombre d'Autochtones âgés continuent de connaître une situation socio-économique difficile et ne disposent donc vraisemblablement pas du pouvoir d'achat nécessaire pour gérer et contrôler l'augmentation inévitable des problèmes de santé qui se manifeste avec l'âge. Cela soulève des inquiétudes non seulement pour la santé et le bien-être des personnes âgées dans les populations autochtones canadiennes, mais aussi pour leur subsistance de base et leur capacité de survivre sans appui monétaire supplémentaire. Cela soulève aussi des inquiétudes pour la communauté : du fait que les anciens jouent traditionnellement un rôle si important au sein des communautés autochtones, la perte de leur force et de leur capacité à participer aux activités culturelles en raison de problèmes d'argent ou de santé sont préoccupantes.

Une étude effectuée en Nouvelle-Zélande en 1997 (Durie, Allan et Cunningham, 1997) a évalué les liens entre la participation aux activités culturelles et communautaires et la santé. L'évaluation de la santé et du bien-être de la population âgée était fondée sur les perspectives de santé des Maoris et tenait aussi compte de l'importance des anciens dans la société maori (un rôle et une fonction similaires à ceux des anciens au sein des populations autochtones canadiennes). Elle couvrait au total 400 participants maoris de plus de 60 ans. La recherche a révélé que « en plus des facteurs économiques et sociaux, le bien-être des Maoris âgés était par conséquent conceptualisé en tant qu'interaction entre les perspectives de santé personnelles et la participation à certains aspects essentiels de la société Maori, p. ex., la terre, la langue et les marae (lieux de réunion tribaux) » (Durie et coll., 1997). En approfondissant davantage cette information, l'étude a relevé que les aînés maoris se trouvant à l'échelon le plus bas de l'« indice culturel » (c.-à-d. ceux participant le moins ou les moins aptes à remplir leur rôle culturel) étaient aussi les plus susceptibles d'être en mauvaise santé; c'était le cas même pour les personnes ayant des normes de santé de base et des circonstances relatives au milieu similaires. Les chercheurs ont conclu par conséquent que « la perception qu'ont les Maoris du bien-être est étroitement associée à la capacité de remplir un rôle culturel. Les mesures du bien-être qui n'intègrent pas

l'identité culturelle ne pourront pas traduire la nature du bien-être telle qu'elle est vécue par les Maoris » (Dion, Stout et Kipling, 2003; Durie et coll., 1997). Cela rejoint et développe la vision de la santé qui s'est élaborée tout au long de ce mémoire; la santé représente plus que la capacité d'éviter la maladie ou de satisfaire à des mesures spécifiques, mais dépend aussi de facteurs socio-économiques plus généraux qui influencent le bien-être émotionnel, spirituel, mental et économique.

Ainsi que la présente section l'illustre, les risques associés à l'apparition de maladies chroniques augmentent avec l'âge du fait du cumul des risques à toutes les étapes de la vie. Par conséquent, l'âge adulte devient l'arène où la gestion des maladies chroniques devient capitale et où les enjeux associés aux systèmes de soutien et aux pratiques culturelles redoublent d'importance; c'est particulièrement vrai au sein des populations vulnérables, tel que la population autochtone au Canada. En prévision de cela, il est important que le système de santé publique conçoive des services de soutien et des programmes d'éducation à l'intention des aînés afin de pouvoir gérer la maladie et contenir les risques accumulés. Le vécu en matière de santé de la population du troisième âge perçu selon un point de vue englobant toute la durée d'une vie nous aide à comprendre la nécessité de mettre l'accent sur la prévention et la promotion de la santé dès les premières étapes de la vie et de continuer à être vigilants tout au long de cette vie.

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WITNESSES

Wednesday, April 1st, 2009

Champlain Local Health Integration Network:

Dr. Robert Cushman, Chief Executive Officer.

BC Healthy Communities:

Jodi Mucha, Director.

As an individual:

Dr. Kellie Leitch.

TÉMOINS

Le mercredi 1^{er} avril 2009

Réseau local d'intégration des services de santé de Champlain :

Dr Robert Cushman, directeur général.

BC Healthy Communities :

Jodi Mucha, directrice.

À titre personnel :

Dre Kellie Leitch.





Second Session
Fortieth Parliament, 2009

Deuxième session de la
quarantième législature, 2009

SENATE OF CANADA

SÉNAT DU CANADA

*Standing Senate Committee on Social Affairs,
Science and Technology*

*Comité sénatorial permanent des Affaires sociales,
des sciences et de la technologie*

Proceedings of the Subcommittee on

Délibérations du Sous-comité sur la

Population Health

Santé des populations

Chair:

The Honourable WILBERT J. KEON

Président :

L'honorable WILBERT J. KEON

Wednesday, April 1, 2009

Thursday, May 7, 2009 (in camera)

Wednesday, May 27, 2009 (in camera)

Le mercredi 1^{er} avril 2009

Le jeudi 7 mai 2009 (à huis clos)

Le mercredi 27 mai 2009 (à huis clos)

**Issue No. 4
(Volume 3 of 3)**

**Fascicule n° 4
(Volume 3 de 3)**

**Ninth, tenth and eleventh (last)
meetings on:**

The impact of the multiple factors and conditions that
contribute to the health of Canada's populations —
known collectively as the determinants of health

**Neuvième, dixième et onzième (dernière)
réunions concernant :**

Les divers facteurs et situations qui contribuent
à la santé de la population canadienne, appelés
collectivement les déterminants de la santé

INCLUDING:

THE SECOND REPORT OF THE SUBCOMMITTEE

(A Healthy, Productive Canada:

A Determinant of Health Approach)

(Appendices B and C)

**(Eighth Report of Standing Senate Committee on Social
Affairs, Science and Technology)**

Y COMPRIS :

LE DEUXIÈME RAPPORT DU SOUS-COMITÉ

(Un Canada en santé et productif :

une approche axée sur les déterminants de la santé)

(Annexes B et C)

**(Le huitième rapport du Comité sénatorial permanent des
Affaires sociales, des sciences et de la technologie)**

WITNESSES:

(See back cover)

TÉMOINS :

(Voir à l'endos)

THE SUBCOMMITTEE ON POPULATION HEALTH

The Honourable Wilbert J. Keon, *Chair*

The Honourable Lucie Pépin, *Deputy Chair*

and

The Honourable Senators:

Callbeck
Champagne, P.C.
Cook

Eaton
Fairbairn, P.C.

(Quorum 3)

Changes in membership of the subcommittee:

Pursuant to rule 85(4), membership of the subcommittee was amended as follows:

The Honourable Senator Champagne, P.C., replaced the Honourable Senator Stratton (*March 30, 2009*).

The Honourable Senator Stratton replaced the Honourable Senator Champagne, P.C. (*March 27, 2009*).

LE SOUS-COMITÉ SUR LA SANTÉ DES POPULATIONS

Président : L'honorable Wilbert J. Keon

Vice-présidente : L'honorable Lucie Pépin

et

Les honorables sénateurs :

Callbeck
Champagne, C.P.
Cook

Cook
Fairbairn, C.P.

(Quorum 3)

Modifications de la composition du sous-comité :

Conformément à l'article 85(4) du Règlement, la liste des membres du sous-comité est modifiée, ainsi qu'il suit :

L'honorable sénateur Champagne, C.P., a remplacé l'honorable sénateur Stratton (*le 30 mars 2009*).

L'honorable sénateur Stratton a remplacé l'honorable sénateur Champagne, C.P. (*le 27 mars 2009*).

**Act Locally:
Community-based population health promotion**

**A report by
Dr Trevor Hancock
Health Promotion Consultant
Victoria BC**

**for
The Senate Sub-Committee on Population Health**

March 2009

Table of Contents

Executive Summary

1. Introduction
2. Overview of healthy human development
 - 2.1 Population health and human development
 - 2.2. The “right” to human development
 - 2.3 Building community capital – the ‘five capitals’ framework
 - 2.4 New measures of progress
 - 2.5 Building resilience in people and communities
3. Creating healthier communities, enhancing human development
 - 3.1 Healthy communities in Canada
4. Community engagement and capacity building
 - 4.1 Community involvement
 - 4.2 Intersectoral partnerships
 - 4.3 Political commitment
 - 4.4 Healthy public policy
 - 4.5 Asset-based community development
5. New models of community governance for health and human development
 - 5.1 The Tamarack Institute and Vibrant Communities
 - 5.2 Social Planning Councils and Inclusive Cities Canada
 - 5.3 The Vancouver Agreement
 - 5.4 Oujé-Bougoumou – An inspirational Aboriginal community
 - 5.5 Healthy urban governance
 - 5.6 Creating an infrastructure for community governance
6. Barriers to community governance for health and human development
 - 6.1 A fragmented approach to community issues – and the need for a more comprehensive approach
 - 6.2 Absence of a comprehensive national vision
 - 6.3 Outmoded municipal arrangements
 - 6.4 Lack of an infrastructure for community governance
 - 6.5 Funding limitations
 - 6.6 Lack of consensus on support for more universal programs
 - 6.7 Limitations of federal charity regulations and social investments

- 6.8 Burn-out of volunteer sector
- 6.9 Problems sharing Canadian successes

7. Integrated community-based human services

- 7.1 Critical success factors and barriers to integrated human services
- 7.2 Quebec's CLSCs
- 7.3 Community Health Centres in English Canada
- 7.4 Human services integration in Saskatchewan
- 7.5 Healthy Child Manitoba
- 7.6 A vision for integrated health and human development services

8. Towards a national approach to supporting community action for population health and human development.

References

Text Boxes

- 1. Some key propositions for population health promotion and healthy human development at the local level
- 2. Human development – basic concepts and definition
- 3. The Healthy City: Definition and parameters
- 4. Matching funds have changed Seattle's face
- 5. Calgary pursues living wage goal through vibrant communities
- 6. Woodward Building brings mixed-use innovation to DTES
- 7. The story of Oujé-Bougoumou
- 8. Our cities, our health, our future: Acting on social determinants for health equity in urban settings

Figures

- 1. Community capital and human-centred development
- 2. GDP and GPI, USA, 1950 - 2004
- 3. Intersectoral partnerships
 - 3a. Inter-department/Inter-Ministry/ Inter-agency action
 - 3b. Cross-sectoral action
 - 3c. Vertical integration

Tables

- 1. Some implications for selected human services by design levels, CEED proposal for Seaton design competition, 1994

Appendices

Appendix 1: Healthy cities and communities – then

Appendix 2: Healthy cities and communities – now

Appendix 3: Key informants

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Executive Summary

The health of individuals cannot be discussed, understood or acted upon without recognizing that human beings are social animals that have evolved to live in families, social groups and communities. “Community,” therefore, is the crucible for many of the most important determinants of health as the place where we live, learn, work and play – our homes, schools, workplaces and neighbourhoods.

In fact, the Senate Subcommittee on Population Health has identified 12 chief factors or conditions - health determinants – that contribute to or undermine the health of Canadians. Of these 12, a full 10 play out largely at the community level.

This report argues that since so many of these determinants act at the local level, it is here that action must be taken. So what can we do to address some or all of the determinants of health at the community level? What is being done currently in Canadian communities? And how can the federal, provincial and territorial governments support or advance community action for health and human development?

The promotion of healthy human development is a key concept underlying health promotion at the community level. The task of promoting optimal human development - so that everyone develops as fully as possible and achieves their maximum potential as a human being - is, or should be, the central purpose of all levels of government. The same focus and energy given to the development of a country’s economy should be applied to the development of a country’s people. This report begins by developing the conceptual basis that underlies healthy human development, particularly the notion of building the five forms of capital – natural, economic, social, built, and human – that together form ‘community capital’. These concepts of what our societal purpose should be need to become the key markers of our progress. For this to be realized, new measures are required that better capture and integrate these various dimensions of personal, community and societal wellbeing.

Finding an appropriate balance between these often competing forms of capital in a way that engages people from all sectors of the community, and ideally maximizing all these forms of capital simultaneously, is at the heart of the art of local governance for health and human development. The process of engaging the whole community in finding the right balance is the process of governance – “the sum of the many ways individuals and institutions, public and private, plan and manage the common affairs of the city” (UN Habitat, 2002). Among the key elements of governance for health at the community level are four identified more than 15 years ago by the WHO Europe Healthy Cities Project: community involvement, intersectoral action, political commitment and healthy public policy.

Achieving improved governance for health and human development requires investing in building resilience - the “ability to not only cope but also to thrive in the face of tough problems and continual change” (Torjman, 2007) – in both people and communities, and in the process and structures needed for community governance.

This report examines a host of ways that Canada is creating healthier communities and enhancing human and community development. A key point that emerges from the report is that there is no universal model that can or should be applied to all communities. What

is needed is a model process that enables, supports and empowers communities to engage with their citizens – and the various public, non-profit, community and private-sector organizations in the community – to develop a shared vision and unique, tailored actions to achieve that vision.

A second – and related – key point to emerge is that this approach must be based on the community's strengths and assets, not its weaknesses and dysfunctions. There is a growing number of initiatives in Canada that use this approach, including:

- **The Healthy Communities Movement** – Arising in part out of the 1986 Ottawa Charter, Canada's healthy communities movement has existed for more than 20 years. Although the national initiative disappeared in the budget cuts of 1991/92, Quebec's Villes et Villages en Santé and Ontario's Health Communities Coalition are both highly active. BC's Healthy Communities initiative reemerged in 2005, with new provincial funding. All three provincial networks take a broad approach that links environmental, social and economic factors together and they all facilitate and support collaborative action within communities. The Quebec initiative has a particularly strong focus on and link to municipal governments, while the Ontario initiative has a strong focus on community-based organizations and networks; the BC initiative, learning from the experience of its two senior partners, does both, being located organizationally at the Union of BC Municipalities, but having a strong focus on community capacity building.
- **Community engagement and capacity building** – Five essential strategies build on a community's existing capacity to improve population health and human development;
 - **Community involvement** that moves from people being passive recipients of services to empowered participants and leaders;
 - **Intersectoral partnerships** that cross boundaries whether between government department or ministries (whole of government); across multiple sectors such as through the creation of broad coalitions' or through vertical integration such as linking local, provincial and federal governments;
 - **Political commitment**, ideally that lasts longer than a single term and that fosters community engagement and capacity building;
 - **Healthy Public Policy** where government action in non-health sectors, such as transportation or housing policy, is designed to have as one benefit the improvement of the health of the population; and
 - **Asset-based community development**, an approach that empowers both individuals and communities by focusing on community strengths and on individuals' with assets and skills. This approach is empowering rather than disempowering and treats individuals and communities as having intrinsic merit and ability rather than simply being bundles of problems that need to be solved or as helpless clients with needs to be met.

- **New models of community governance for health and human development:** Exciting work in community engagement is taking place across Canada through such community initiatives as *Vibrant Communities* and *Inclusive Cities Canada*, which are both tapping into community strengths to address health and human development. These efforts span the full dimension of ‘community’ in Canada, from the Vancouver Agreement (a new urban development agreement that links the federal, provincial and municipal governments as well as bringing in multiple other partners to address complex issues in Vancouver’s Downtown Eastside) to the small but inspiring Cree community of Oujé-Bougoumou. Yet despite very positive developments, barriers impede progress, including outdated municipal constitutional arrangements; lack of a comprehensive national vision for healthy community development; lack of a complete basket of universal programs to address determinants which community action can then enhance; constant lack of funding and narrow approaches to funding; lack of a community infrastructure of governance for health and human development; the limitations of federal charities law, under which most community action falls; burnout of volunteers; and lack of effective information sharing on successful programs, particularly between French and English Canada.
- **Integrated community-based human services** - An important subset of community-based human development is integrated human services that coordinates the actions of individuals and services. The concept is to provide services to the public that streamlines and simplifies client access, increases efficiency, provides superior care and bridges traditional organizational or program boundaries. Longstanding models of integrated human services include Quebec’s CLSCs and community health centres in English Canada, but despite a great deal of evidence of their success, typical barriers to further expansion include funding models, turf wars and ideological battles. Saskatchewan has some of the greatest success with integrating services and a new integrated service initiative, Healthy Child Manitoba, is capturing attention. A vision of integrated human services developed from the household level up is presented to conclude this section.

Finally, the report proposes a vision for a national approach to supporting asset-based community action for population health and human development.

1. Many of the determinants of health have their effects at the community level, in the settings – homes, schools, workplaces, neighbourhoods – where people live, learn, work and play.
2. Communities – even the most challenged and disadvantaged communities such as the Cree community of Ouje-Bougoumou described in this report – have significant and sometimes astonishing strengths, capacities and assets that can be used by the community to address their problems and to enhance their health, wellbeing and level of human development.
3. Provincial and federal governments, philanthropic organizations and the private sector would be wise to recognize the strengths inherent in communities, and to

build upon and enhance community capacity by adopting the strategy of investing in asset-based community development.

4. Such a strategy requires, among other things:
 - a. Recognizing the vital role played by municipal governments in creating the conditions for health and human development, making them key partners, and strengthening their powers (including their taxing powers).
 - b. Adopting a holistic ‘whole-of-government’ approach to issues of population health and human development at all levels of government, from the federal to the local.
 - c. Encouraging and supporting the creation of community governance processes and structures that enable the many stakeholders in the community – public, non-profit, private and community sectors, as well as individual citizens – to identify and define local community issues and solutions and to develop long-term, asset-based strategies to address them.
5. This in turn requires a commitment by governments and philanthropic organizations to long-term funding of this community governance infrastructure. Specifically this means a commitment to provide less narrowly targeted and short-term funding and more long-term general funding that communities can use in ways that they see fit to address the challenges they have defined and to build the community capacity they require.
6. At both the national and provincial levels, there is a need to establish (or where they already exist, to greatly strengthen) national and/or provincial organizations that can support the creation of healthy schools, healthy workplaces and healthy communities. These organizations would facilitate and support the creation of community governance infrastructures, undertake research, share knowledge and experience, develop tools and ‘train the trainers’.
7. Any national effort to improve population health and human development health through community-based action to create healthier communities needs to include a national effort to develop new measures of progress, so that our progress towards these broad societal goals can be tracked. These new measures need to be applicable at all levels from the national to the local, and their development needs to be done in partnership with communities, as part of the development of the community’s capacity to understand itself and its situation, a necessary prerequisite for taking action
8. As one part of building (on) community capacity, governments should develop more integrated systems of human development services. Particularly in disadvantaged communities, these services should be co-located close to the people who use or need them; they should be easy to use and navigate (‘one-stop shopping’) and where possible they should be housed in a single facility that maximizes the use of the shared space throughout the day.

1. Introduction

In evolutionary terms, humans are social animals. We evolved in families and larger social groups, and social interaction is an essential part of our wellbeing. Epidemiological research has consistently shown that isolation and loneliness are bad for health. So contrary to the wishes of some ideologues, there is such a thing as community and society, and the health of individuals cannot be discussed, understood or acted upon without recognizing this fact.

This report is based on the recognition that ‘community’ is the crucible for many of the most important determinants of health. As the place where we live, learn, work and play – our homes, schools, workplaces and neighbourhoods – it is our most immediate physical environment;¹ as a network of social relationships based in but extending beyond these places into ‘non-spatial’ and virtual communities, it is a fundamental source of our identity and social wellbeing, second only to our family.

This is not to suggest that ‘community’ is a panacea, or to romanticize community. Communities, both as places and as networks of social relationships, can harm health as well as help it; in fact, part of what makes a community ‘healthy’ is that it protects its members – especially its most vulnerable members – against harm arising from its physical, social, economic and other environments.

Nor is it to suggest that health (or disease) stems only from community. In fact, we know that health also comes from our genes, on the one hand, and from the health of the regional and global ecosystems that constitute our ‘life support systems’, on the other. But just as famed US congressman ‘Tip’ O’Neill once famously remarked that “all politics is local”, so might we suggest that all health is local.

This idea is strengthened by examining the set of determinants of health identified by the Senate Subcommittee on Population Health. Over the past year, the Subcommittee has published four in depth reports examining various aspects of Population Health Policy. These reports have clearly established that multiple factors and conditions – or “determinants” – contribute to or undermine the health of Canadians. The Subcommittee reports have identified the following twelve health determinants:² Those that are starred with asterisks are the ones that play out largely in Canadian communities – the cities, towns, neighborhoods, and regions where Canadians live, learn, work and play.

¹ It is worth recalling that in Canada we are 80% urbanized and we spend 90% of our time indoors (and a further 5% in vehicles), so the built environment is by far our most immediate and important environment. This is not to ignore the fact that we are also part of regional and global ecosystems, whose life support systems profoundly affect our ultimate wellbeing.

² This document uses the list provided by the Senate Subcommittee, but this list of determinants differs slightly from some other recent Canadian sources. The Public Health Agency of Canada uses seven broad categories: socio-economic environment; physical environments; early childhood development; personal health practices; individual capacity and coping skills; biology and genetic endowment; and health services. The F/P/T Working Group on Population Health uses the following: income, education, employment, housing and the built environment, the natural environment, early childhood experiences, literacy, social support, health choices, access to preventive health services, and the general empowerment people have to control decisions in their own lives.

- early childhood development; *
- education;*
- employment and working conditions;*
- income and social status;*
- social environments;*
- physical environments;*
- social support networks;*
- lifestyle, personal health practices and coping skills;*
- biology and genetic endowment
- gender
- culture (* - can have strong community element)
- health care*

As the Sub-committee noted in its Fourth Report in April 2008, it has been suggested that 15 % of the population's health is attributable to biology or genetic factors, 10 % to the physical environment and 25 % to the reparative work of the health care system. Fully 50 % of population health is attributable to the social and economic environment. That means that, since the community also represents the built physical environment where Canadians spend almost all of their time, as well as the local delivery of health care services, more than 75 % of the health determinants exert their influences on the Canadian population in the community setting – homes, schools, neighborhoods, workplaces, towns, and cities.

Moreover, the creation of the conditions needed for health is often local in nature, through the work of municipal governments, Band councils, local NGO or private sector organizations, or in some cases through the regional offices of provincial or federal governments.

This report argues that since so many of these determinants act at the local level, it is here that action must be taken. So what can we do to address some or all of the determinants of health at the community level? What is being done currently in Canadian communities? And how can the federal, provincial and territorial governments support or advance community action for health and human development?

It is important to note that the 2008 Report on the State of Public Health in Canada, the first Annual Report of the Chief Public Health Officer of Canada, explicitly called for the strengthening of communities in Canada to address health determinants, noting people living closest to the problem are often closest to the solution. His report said communities must be honored and supported to develop their own responses, to build on existing knowledge, experience and energy at the ground level. This recommendation was echoed in the 2008 WHO Report on the Social Determinants of Health, which noted as one of its key recommendations that health and health equity must be at the heart of urban governance and planning, particularly where poverty or poor living conditions are

impacting populations' health. In addition, a background document to the WHO fact-finding process, *Our Cities, Our Health, Our Future: Acting on social determinants for health equity in urban settings*, noted that, "Urban development and town planning are key to creating supportive social and physical environments for health and health equity." It noted the health sector needs to establish partnerships with other sectors and civil society to carry out a broad spectrum of interventions.

2. Overview of healthy human development

"Salus populi suprema lex"

(The welfare of the people is the supreme law)

Cicero - *De Legibus* (approx 45 BC)

It is an old but sometimes overlooked truth that the ultimate purpose of the governance of a society is the welfare of its people. Some key propositions that should form the foundation of population health promotion and healthy human development at the local level are listed in Text Box #1.

The first is that population health is a key element in a broader concept, namely human development, and that improving the health of the population is subsumed in a wider task; seeking to ensure that everyone develops as fully as possible and achieves their maximum potential as a human being.

Second, this task is - or should be – the central purpose of government. The UN itself has declared that "the human person is the central focus of development" (UN Declaration on the Right to Development, 1986) and has made this the focus of its Human Development Index.

Yet curiously, human development is seldom explicitly the focus of the work of governments; more often the focus seems to be on economic development - perhaps most famously encapsulated in Bill Clinton's reminder to himself when running for President that "it's the economy, stupid!" This report argues that the economy is a means to the end, which is human rather than economic development ("it's the people, stupid!") or, as more eloquently put in a report on human and ecosystem health from the Canadian Public Health Association in 1992:

"Human development and the achievement of human potential requires a form of economic activity that is environmentally and socially sustainable in this and future generations."

Third, human development is a function not only of economic development but of social development and of sustainable development of both the built and natural environments.

The fourth key point that it is in the settings where people lead their lives – their homes, schools, workplaces, recreational places, neighbourhoods and communities - that health is created and human beings are developed. It is there that people can be meaningfully engaged, and where the promise of health promotion – "the process of enabling people to increase control over and improve their health" (WHO, 1986) – can be most readily realized.

A fifth key point is that human development should be the focus not only of governments (at all levels) but of governance. The UN's Habitat agency defines governance (in the context of urban governance) as

“the sum of the many ways individuals and institutions, public and private, plan and manage the common affairs of the city.”

This approach, of course, should be applied to all levels of government. What is important in this definition, no matter to what level it is applied, is that governance involves individuals as well as institutions, and the private realm as well as the public realm. Together they are engaged in the planning and management of the city's common affairs, presumably for a common purpose. What higher common purpose can there be than ensuring that all the members of the society and community achieve the maximum level of health, wellbeing and human development of which they are capable? Who can doubt that not only individuals but communities and enterprises would thrive in such a situation?

Sixth, communities – or in a political sense, municipalities – are particularly important because they are the level of government closest to people, and they contain the other settings. Thus governance for health and human development must have a strong local dimension, while recognizing the importance of supportive provincial and federal policies and programs.

Seventh, an important aspect of local human-centred development is an integrated system of community-based human services. Such a system would be built from the household level up, by examining how human development can be supported at every level and from every dimension, as seen from the perspective of the individual citizen, be they infant, child, youth, adult or senior citizen.

Finally, such a system must be based on and respectful of the capacity of individuals and communities, and must empower – not dis-empower – and enable – not disable them; it must build on capacity.

Throughout the report, examples are given and stories told that make it clear that these ideas are not just a pipe dream, but that they are feasible. Even if the entire system described here does not yet exist, many if not all of the component parts already exist somewhere in Canada or elsewhere in the world.

Text Box #1: Some key propositions for population health promotion and healthy human development at the local level

Some key concepts underlie the foundation of population health promotion at the community level. This foundation concerns the promotion of healthy human development:

1. Population health is a key element in a broader concept, namely healthy human development so that everyone develops as fully as possible and achieves their maximum potential as a human being.
2. The task of promoting optimal human development is - or should be – the central purpose of all levels of government. The same focus and energy given to the development of country's economy should be applied to the development of a country's people.
3. Human development is a result not only of stable and effective economic development but also of social development and of sustainable development of both the built and natural environments.
4. It is in the settings where people lead their lives – their homes, schools, workplaces, recreational places, neighbourhoods and communities - that health is created and human beings are developed.
5. While governments play an important role, the creation of the conditions for healthy human development calls for a broader and more inclusive system of governance at all levels.
6. Communities therefore – or in a political sense, municipalities – are particularly important because they are the level of government closest to people, and they contain the other settings. Thus governance for health and human development must have a strong local dimension, while recognizing the importance of supportive provincial and federal policies and programs.
7. An important aspect of local human-centred development is an integrated system of community-based human services. An ideal system of local, community-based human development would be built from the household level up and supported at every level and from every dimension, as seen from the perspective of the individual citizen and his or her needs, be they infant, child, youth, adult or senior citizen.
8. At the same time, such an ideal community-based system must have as its foundation respect for the capacity and autonomy of individuals and communities, and must empower – not disempower – and enable. It must build on their capacity to recognize and meet their own needs.

2.1 Population health and human development

Health, the World Health Organization famously declared 60 years ago, is a state of complete physical, mental and social wellbeing. The inclusion of social wellbeing signals that the social context of the individual is of great importance, that health depends at least in part on social relations. Over the years, the list of items upon which health depends - the determinants of health – has grown considerably. In the famed Lalonde Report of 1974, it was suggested that there were four 'health fields' – lifestyle, environment (physical, social and economic), health care services and human biology - and that future improvements in the health of Canadians would depend primarily upon the first two of

these. More recently, the list was expanded by the Population Health Research Program of the Canadian Institute of Advanced Research and then by the (Canadian) Advisory Committee on Population Health to the set of 12 determinants recognized by the Senate Sub-Committee on Population Health.

It was the WHO's 1986 Ottawa Charter on Health Promotion, however, that noted that health is not the ultimate goal in life but rather that it is "a resource for everyday life, not the objective of living", that "good health is a major resource for social, economic and personal development and an important dimension of quality of life". Health, then, is but one part of a full or good life, but one part of what we aspire to.

This begs the question as to what we should aspire to for human beings. One answer is that they each develop to the fullest possible realization of their potential, recognizing that every individual has differing potential, and that their potential includes, but goes beyond, a life lived in complete physical, mental and social wellbeing. The Centre for Human Potential and Public Policy at the University of Chicago defines human potential as:

"motivation, human intelligence, social and emotional development, ethics and morality, and a sense of civic responsibility"
(www.harrisschool.uchicago.edu/research/chppp/)

Others might add to this list creativity and a capacity for innovativeness, a sense of empathy and caring for others (including the non-human species, and nature as a whole). The development of such human potential for all is an ambitious but worthy goal – recognizing that a goal is, as the US Public Health Service put it 30 years ago "a timeless statement of aspiration".

One of the most far-reaching and globally recognized efforts to understand and promote human development over the past 20 years has been the development by the UN Development Program (UNDP) of the Human Development Index (see Box #2). It is notable the extent to which this work reflects both a 'determinants of health' approach and the concept of human potential.

Text Box #2: Human development – basic concepts and definition

Human Development is a development paradigm that is about much more than the rise or fall of national incomes. It is about creating an environment in which people can develop their full potential and lead productive, creative lives in accord with their needs and interests. People are the real wealth of nations. Development is thus about expanding the choices people have to lead lives that they value. And it is thus about much more than economic growth, which is only a means —if a very important one —of enlarging people's choices.

Fundamental to enlarging these choices is building human capabilities —the range of things that people can do or be in life. The most basic capabilities for human development are to lead long and healthy lives, to be knowledgeable, to have access to the resources needed for a decent standard of living and to be able to participate in the life of the community. Without these, many choices are simply not available, and many opportunities in life remain inaccessible.

"The basic purpose of development is to enlarge people's choices. In principle, these choices can be infinite and can change over time. People often value achievements that do not show up at all, or not immediately, in income or growth figures: greater access to knowledge, better nutrition and health services, more secure livelihoods, security against crime and physical violence, satisfying leisure hours, political and cultural freedoms and sense of participation in community activities. The objective of development is to create an enabling environment for people to enjoy long, healthy and creative lives."

Mahbub ul Haq, Founder of the Human Development Report

This way of looking at development, often forgotten in the immediate concern with accumulating commodities and financial wealth, is not new. Philosophers, economists and political leaders have long emphasized human wellbeing as the purpose, the end, of development. As Aristotle said in ancient Greece, "Wealth is evidently not the good we are seeking, for it is merely useful for the sake of something else."

"Human development is a process of enlarging people's choices. Enlarging people's choices is achieved by expanding human capabilities and functionings. At all levels of development the three essential capabilities for human development are for people to lead long and healthy lives, to be knowledgeable and to have a decent standard of living. If these basic capabilities are not achieved, many choices are simply not available and many opportunities remain inaccessible. But the realm of human development goes further: essential areas of choice, highly valued by people, range from political, economic and social opportunities for being creative and productive to enjoying self-respect, empowerment and a sense of belonging to a community. The concept of human development is a holistic one putting people at the centre of all aspects of the development process."

UNDP Human Development Reports Glossary

Source: Human Development Reports, UN Development Program;
<http://hdr.undp.org/en/humandev/>

2.2 The “right” to human development

"The concept of human development is a holistic one putting people at the centre of all aspects of the development process."

UNDP Human Development Reports Glossary

In recognition of the centrality of the human dimension to development, the UN General Assembly in 1986 adopted a "Declaration on the Right to Development" stating that "the human person is the central subject of development", and called upon member states "to ensure access to the basic resources, education, health services, food, housing, employment and the fair distribution of income." (Sustainable Human Development. United Nations Economic Commission for Africa, 1995)

A year later, the World Commission on Environment and Development defined sustainable development with a strong reference to meeting the needs of people:

"development which meets the needs of the present without compromising the ability of future generations to meet their own needs" (WCED, 1987)

This focus on human development emerged more strongly at the UN Conference on Environment and Development in Rio de Janeiro in 1992. The first principle of the Rio Declaration is:

"Human beings are the centre of concern for sustainable development. They are entitled to a healthy and productive life in harmony with nature."

While initially focused on environmentally sustainable economic development, the concept became broadened to include social sustainability (e.g. BC Roundtable on Environment and Economy, 1993). Thus it has become common to consider sustainability in terms of three "pillars" or "spheres" or forms of "capital", namely environmental, social and economic components. It is the interaction of these three components that determines the level of human development, which is a fourth form of "capital" (Ekins, Mayer and Hutchinson, 1992; World Bank, 1995). Thus health, quality of life and human development should be considered as outcome measures of successful environmentally and socially sustainable economic activity.

These concepts are integrated in a 1992 Canadian Public Health Association Taskforce report on Human and Ecosystem Health which suggested that:

"Human development and the achievement of human potential requires a form of economic activity that is environmentally and socially sustainable in this and future generations".

while the World Summit for Social Development, also in 1995, noted that

". . . economic development, social development, and environmental protection are interdependent and mutually reinforcing components of sustainable development, which is the framework of our efforts to achieve a higher quality of life for all people" (Cited in Health Canada, 2000)

2.3 Building Community Capital – The ‘five capitals’ framework

While people should be the central focus for all forms of development, the central focus for human development - as noted in the introductory section - should be the community where they live and lead their lives; the better the community, the better the health, wellbeing and level of human development of the people who live in it. Putting people at the heart of community development, and putting human and community development at the heart of public policy and societal governance, needs to become a priority.

One way to understand this is shown in Figure 1, which is a recently expanded version of a conceptual model initially developed with respect to the concept of a healthy city or community (Hancock, 1993), and which has been quite widely used. The model uses the concept of ‘community capital’, which is the combination of the total ‘wealth’ of the community, using the ‘four capitals’ concept noted above and adding a fifth form of capital, the ‘built capital’ that is the dominant environment of Canadians today.³ The model shows:

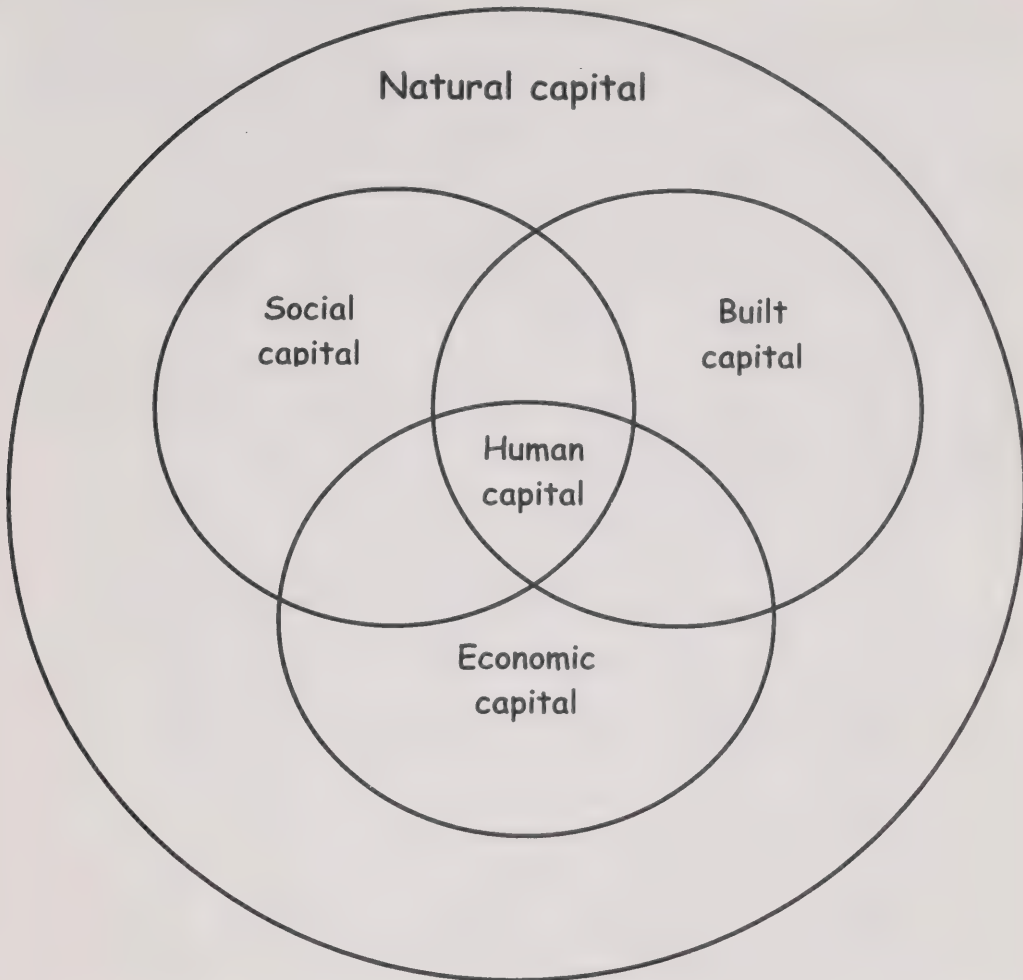
- Human development is the product of the interaction of social, economic and built capital, within the context of natural capital.
- Conceptually, the more there is integration (overlap) in the development of social, economic and built capital, the greater the level of human capital.
- There needs to be some balance between all these forms of capital; in particular, building one form of capital by depleting other forms of capital is not a viable strategy.
- The combination of these forms of capital cannot exceed the natural capital (ecosystem health and integrity, resource sustainability, life support systems, carrying capacity).

It is important to note that social capital is distinct from human capital. Human capital is the sum of the capacities or realised potential of each individual in a community or a city; it is vested in the individual, whereas

“Social capital does not exist within any single individual but instead is concerned with the structure of relationships between and among individuals.” (Coleman, 1988)

³ “The built environment is part of the overall ecosystem of our earth. It encompasses all of the buildings, spaces and products that are created, or at least significantly modified, by people. It includes our homes, schools and workplaces, parks, business areas and roads. It extends overhead in the form of electric transmission lines, underground in the form of waste disposal sites and subway trains and across the country in the form of highways.” Health Canada, Health and Environment (1997)

Figure 1: Community capital and human-centred development



The concept of 'social capital' has come to be dominated by Putnam's concept of informal social networks and connections (Putnam, 1993), and related ideas. However, the structure of our relationships with each other needs to be understood in at least two other dimensions:

- the 'formal' social capital represented by the system of social programs we have created – pensions, employment insurance, health care, social assistance, social services, public education etc
- The 'invisible' social capital of constitutional, legal and political systems we have built over many hundreds of years, and that govern our interactions in a

democratic society and within the rule of law, in ways that we may not always be conscious of.

Thus human development is dependent upon human-centred social and economic development and human-centred development of the built environment, and within the constraints imposed by natural systems. The governance of the various interactions between these different dimensions, the finding of an appropriate balance between these often competing dimensions in a way that engages people from all sectors of the community, the maximization – ideally – of all these forms of capital simultaneously – is at the heart of the art of local governance for health and human development.

Other organizations have also used the five capitals concept, but with slight variations. The UK Department for International Development, which spearheads the UK government's action against world poverty, widely promotes what it calls a "livelihoods approach" which uses a five capitals framework.

As they note, people and their access to assets are at the heart of livelihoods approaches. In the original DFID framework, 5 categories of assets or capitals are identified, although subsequent adaptations have added others, such as political capital (power and capacity to influence decisions). The original 5 categories are:

- human capital: skills, knowledge, health and ability to work
- social capital: social resources, including informal networks, membership of formalised groups and relationships of trust that facilitate co-operation
- natural capital: natural resources such as land, soil, water, forests and fisheries
- physical capital: basic infrastructure, such as roads, water & sanitation, schools, ICT; and produced goods, including tools and equipment
- financial capital: financial resources including savings, credit, and income from employment, trade and remittances

The DFID notes assets can be destroyed or created as a result of the trends (economic, political) shocks (war, conflict, natural disasters) and seasonal changes that make individuals vulnerable in their daily lives. Policies, institutions and processes can have a great influence on access to assets - creating them, determining access, and influencing rates of asset accumulation. Those with more assets are more likely to have greater livelihood options with which to pursue their goals and reduce poverty.⁴

2.4 New measures of progress

If the central purpose of government – and indeed of societal and community governance – is the enhancement of health, well being and human development and the creation of community capital, then it follows that our progress as a nation, province, territory, municipality or community should be measured in those terms. There has been a growing awareness of the limitations of our current system of measuring progress - too often it seems that all that counts is GDP, which is a very imperfect measure of the wellbeing of a

⁴ More information about the DFID can be found at www.dfid.gov.uk. Other information about livelihoods approach is available from the International development clearinghouse Eldis Organization, www.eldis.org.

society. Yet it is a truism in the world of indicators that “we get what we measure” – so if we use imperfect measures, we should not be surprised if we get imperfect results.

A great deal of work has been done over the past few decades to develop new measures of progress. In one way or another, they all try to incorporate most if not all of the five forms of capital and the concept of human development noted above. Some key initiatives of particular relevance to Canada are noted here.

- Human Development Index (HDI): Developed by the UNDP, this indicator has been in use for some 20 years. The first Human Development Report (1990) introduced a new way of measuring development by combining indicators of life expectancy, educational attainment and income into a composite human development index, the HDI. The breakthrough for the HDI was the creation of a single statistic which was to serve as a frame of reference for both social and economic development. Over time, the Index has become more complex and sophisticated, with the addition of the Gender-related Development Index (GDI, which adjusts the HDI for gender inequality); the Gender Empowerment Measure (GEM, a measure of agency that evaluates progress in advancing women's standing in political and economic forums) and the Human Poverty Index (HPI), which uses indicators of the most basic dimensions of deprivation: a short life, lack of basic education and lack of access to public and private resources (see <http://hdr.undp.org/en/humandev/hdi/>)

For many years, Canada has ranked at or near the top of the international ‘league table’ for HDI; in the 2008 report (based on 2006 data) it ranked third. However, it ranked 83rd out of 157 nations for the GDI (although the spread is very narrow across all nations), and 11th on the GEM.⁵ However, within Canada, there are some stark differences between Aboriginal and non-Aboriginal people. A study comparing the HDI for Registered Indians and the rest of the Canadian population (Cooke, Beavon and McHardy, 2004) found that the Canadian HDI in 1981 was 0.806 and rose to 0.880 in 2001,⁶ while the HDI for the Registered Indian population was 0.626 in 1981, rising to 0.765 in 2001. While the gap between the two populations narrowed from 0.23 in 1981 to 0.11 by 2001, a score of 0.765 put registered Indians at the same level as Kazakhstan, which ranked 76th out of 175 nations in 2001 (UNDP, 2003).

- Genuine Progress Indicator (GPI): Based on the work of Herman Daly and John Cobb (1989) who developed the Index of Sustainable Economic Wellbeing, the GPI was created by Redefining Progress, a San-Francisco-based organization, in 1995. *“The GPI starts with the same personal consumption data that the GDP is based on, but then makes some crucial distinctions. It adjusts for factors such as income distribution, adds factors such as the value of household and volunteer work, and subtracts factors such*

⁵ http://hdrstats.undp.org/2008/countries/country_fact_sheets/cty_fs_CAN.html

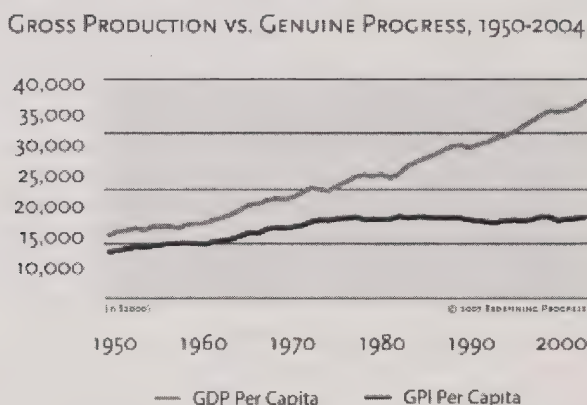
⁶ Curiously, the UNDP gave Canada a score of 0.937 in 2001, which ranked Canada 8th; a score of 0.880 would have ranked Canada with Slovenia in 29th place. Clearly, there are some methodological differences between the UNDP’s estimation of HDI and that of the Canadian authors.

*as the costs of crime and pollution.*⁷ It can be used at national, provincial or local levels.

The measurements that make up the GPI include income distribution; housework, volunteering, and higher education; crime; resource depletion; pollution; long-term environmental damage; changes in leisure time; defensive expenditures; lifespan of consumer durables & public infrastructure, and dependence on foreign assets.

The difference between GDP and GPI is very revealing; the annual accounts of GDP and GPI for the USA from 1950 to 2004 (the most recent update done by Redefining Progress) reveals the truth behind the phrase “doing better but feeling worse”. While GDP has risen steadily, the GPI has been stagnant since the 1970s (see Figure 2).

Figure 2: GDP and GPI, USA, 1950 - 2004



In Canada, GPI Atlantic has worked to develop the GPI at the provincial level for Nova Scotia, and has piloted its development at the community level in three communities in Nova Scotia - Kings County, Glace Bay and Halifax,⁸ while the Pembina Institute developed the GPI for Alberta in 2000 and updated it in 2005.⁹

- **Gross National Happiness (GNH):** First proposed by the King of Bhutan in the 1970s, the GNH expresses the Buddhist notion that the ultimate purpose of life is inner happiness. The GNH Index is a single number that is intended “to reflect the happiness and general well-being of the Bhutanese population” and is calculated from three broad sets of indicators; GNH status indicators, GNH

⁷ www.rprogress.org/sustainability_indicators/genuine_progress_indicator.htm

⁸ www.gpiatlantic.org/community.htm

⁹ www.greenoeconomics.ca/AlbertaGPI

demographic indicators and GNH causal and correlation indicators. The GNH indicators include nine core dimensions:

- Psychological well-being
- time use
- community vitality
- culture
- health
- education
- environmental diversity
- living standard, and
- governance.¹⁰

The GNH has come to international attention in recent years, and the Second International Conference on the GNH was held in Nova Scotia in 2005, with funding support from both IDRC and CIDA and support from many partners, including GPI Atlantic.¹¹ Researchers affiliated with GPI Atlantic have worked with researchers in Bhutan and have recently (Spring 2009) undertaken a pilot GNH survey in Victoria BC as part of a series of such pilot surveys in several countries (Mike Pennock, personal communication).

- Canadian Index of Wellbeing (CIW): The Atkinson Charitable Foundation has been working with a number of national organizations and with communities across Canada since 1999 to develop the CIW. In particular it is creating partnerships with the Community Foundations of Canada on their Vital Signs initiative and the United Way's Action for Neighbourhood Change initiative, and also has links to FCM's Quality of Life reporting initiative¹² and to Vibrant Communities. The Index has 8 domains – quite similar to those in the GNH – that will be blended into a composite index:

- Healthy populations
- community vitality
- time use
- educated populace
- ecosystem health

¹⁰ www.grossnationalhappiness.com/gnhIndex/introductionGNH.aspx

¹¹ www.gpiatlantic.org/conference

¹² Led by the Federation of Canadian Municipalities (FCM), the Quality of Life Reporting System (QOLRS) measures, monitors and reports on social, economic and environmental trends in Canada's largest cities and communities. The QOLRS is a member-based initiative. Starting with 16 municipalities in 1996, the QOLRS has grown to 23 communities in seven provinces. (Source: www.fcm.ca/english/view.asp?x=477)

- arts and culture
- civic engagement, and
- living standards.

“Most importantly, the CIW will shine a spotlight on how these important areas are interconnected”. Like the GPI it will “will treat beneficial activities as assets and harmful ones as deficits”, and also like the GPI it will be calculated at the national, provincial, regional and community levels.¹³

Clearly, there is a growing interest at all levels from the international to the local, to develop alternative measures of progress; moreover, many of these efforts share many common elements. There has been a particularly strong interest over the past couple of decades to develop broader sets of indicators at the community level, including indicator sets for healthy communities, sustainable communities, liveable communities and safe communities, as well as indicators of the quality of life.¹⁴ What they all have in common is an attempt to look at communities in a holistic manner, often using categories of environmental, social, economic and human wellbeing or development.

Moreover, and importantly, they almost always include a community engagement strategy, since the development and use of indicators by the community is seen as an important part of the process of community capacity building.

Any national effort to improve population health and human development health through community-based action to create healthier communities needs to include a national effort to develop new measures of progress such as those noted above, so that our progress towards these broad societal goals can be tracked. These new measures need to be applicable at all levels from the national to the local, and their development needs to be done in partnership with communities, as part of the development of the community’s capacity to understand itself and its situation, a necessary prerequisite for taking action.

2.5 Building resilience in people and communities

An important concept related to community capital is resilience – in some ways, this is the summation at a personal and community level of the creation of all forms of community capital. In her recent book “Shared Space: The Communities Agenda” Sherri Torjman, Vice-president of the Caledon Institute of Social Policy, suggests that the goal of what Paul Born of the Tamarack Institute calls the ‘communities agenda’ is to “promote resilience in order to build strong, vibrant communities” (p3).

Drawing from two very different but surprisingly complementary fields of research and practice – ecology and mental health – she suggests that resilience – the “ability to not only cope but also to thrive in the face of tough problems and continual change” (p5) – is a desirable property of both people and communities (and of course, ecosystems).

There is in fact a reciprocal relationship between resilient people and resilient communities. Not surprisingly, then, Torjman argues that building resilience requires

¹³ www.atkinsonfoundation.ca/ciw

¹⁴ See for example the Community Indicators Consortium, a learning network and community of practice for people engaged or interested in the field of community indicators and their application. Their seventh international conference will take place in Seattle in Fall 2009. (www.communityindicators.net/)

investing in both personal capacity ('the skills, abilities and assets of individuals and households') and community infrastructure ('the supply of amenities and resources that contribute to wellbeing' – p 18). Specifically, this means investing in:

- The provision of basic needs (decent affordable housing, adequate income, health protection)
- The development of basic coping skills and capacities (early child development, literacy, empathy, problem-solving, as well as systems of social support and social capital)
- active participation in society and a sense of agency, arising from public discourse, engagement in decision-making, voluntarism, participation in recreation – and the creation of the public spaces needed for these activities
- creating opportunity through training and skills development, community economic development, and building public and private, personal and collective assets.

3. Creating healthier communities

"The greatest contribution to the health of the nation over the past 150 years was made not by doctors or hospitals but by local government."

--Dr. Jessie Parfitt, in *The Health of a City: Oxford, 1770-1974*

History teaches us why it makes sense to address population health at the community level. As Dr. Thomas McKeown noted in his famous writings in the 1970s (McKeown, 1978), the great gains of life expectancy and human health over the last 200 years came from clean water, improved sanitation and sewage control, better nutrition and increased standards of living – all occurring at the community level, and none of them the result of improved health care per se.

There is in fact a very long history linking health and cities, and the modern-day public health movement has its origins in concerns about the health of towns in England in the mid-19th century (see Appendix 1).

The modern-day healthy cities and communities movement has its origins in the concept of health promotion as it was developed in Canada and in Europe in the mid-1980s, and more specifically in a 1984 conference on healthy public policy in Toronto, which led to the creation of the WHO Europe Healthy Cities Project in 1986 (see Appendix 2). As such, it is rooted in and is an important expression of the key elements of the Ottawa Charter for Health Promotion and of the 'settings-based approach'¹⁵ recommended in the Charter (WHO, 1986). Thus just as health promotion is seen as "the process of enabling people to increase control over and improve their health", so too is the creation of a healthier city (or community, the preferred term in Canada) seen as a process, one that

¹⁵ 'Settings' are the physical places and social spaces where we lead our lives. Because they are central 'nodes' in our lives, and because they combine the physical and social environments, they can be powerful foci for health promotion programs. Settings-based approaches that are widely adopted in health promotion in Canada and internationally include healthy schools, healthy workplaces, healthy hospitals, healthy prisons, healthy markets, healthy communities and healthy cities. Conceptually, and often in practice, a healthy community or healthy city project can encompass many of the other settings-based programs.

mirrors many of the strategic approaches identified in the Ottawa Charter (building healthy public policy, creating supportive environments, strengthening communities, developing personal skills). This is clearly seen in the definition of a healthy city developed in the original background document prepared for the WHO Europe Healthy Cities Project:

“A healthy city is one that is continually creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.” (Hancock and Duhl, 1986)

Text Box 3: The Healthy City: Definition and Parameters

"A healthy city is one that is continually creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential."

Parameters

1. A clean, safe, high quality physical environment (including housing quality).
2. An ecosystem which is stable now and sustainable in the long term.
3. A strong, mutually-supportive and non-exploitative community.
4. A high degree of public participation in and control over the decisions affecting one's life, health and well-being.
5. The meeting of basic needs (food, water, shelter, income, safety, work) for all the City's people.
6. Access to a wide variety of experiences and resources, with the possibility of multiple contacts, interaction and communication.
7. A diverse, vital and innovative city economy.
8. Encouragement of connectedness with the past, with the cultural and biological heritage and with other groups and individuals.
9. A city form that is compatible with and enhances the above parameters and behaviours.
10. An optimum level of appropriate public health and sick care services accessible to all.
11. High health status (both high positive health status and low disease status).

(Source: Hancock, Trevor and Duhl, Leonard (1986) Healthy Cities: Promoting Health in the Urban Context. Copenhagen, WHO Europe (Also published as WHO Healthy Cities Paper #1 by FADL, Copenhagen, 1988)

The range of issues that might need to be addressed by a healthy city or community initiative is well illustrated by the 'parameters' of a healthy city defined in the original WHO Europe background paper; they are at least as broad as the 'determinants of health' identified more than a decade later by the Advisory Committee on Population Health (see Box #3).

It is also important to note that the end-point is not health per se, but the broader concept of people developing to their maximum potential – human development, in other words. Also, and consistent with its location within the overall health promotion approach, the central purpose is one of empowerment of people – individually and collectively (through their community organizations and political structures) – to improve their health and level of human development. This calls for a long-term approach, where the process of community and local political engagement and empowerment is more important than short-term projects (although they can be important as part of the long-term engagement process). This concept, as with health promotion itself, has always presented a challenge to those whose focus is on narrow and short-term outcomes defined externally to the community (which is often the situation for many government programs, as will be discussed later). In many ways, the healthy cities and communities approach is best seen as an attempt to create a community-based social movement for health, one in which communities are supported in defining for themselves what is important for their health - whatever that may be - and how to go about improving health.

As will also be discussed later, this approach is consistent with a number of other leading-edge initiatives in Canada that employ a similar approach to improving the condition of Canada's communities. They all pose similar challenges to the 'business-as-usual' government approach to community-based action, and all suffer from a similar neglect that needs to be addressed because, together, they point the way forward for community-based action on population health and human development.

3.1 Healthy communities in Canada

Canada has maintained a healthy community movement for more than 20 years. (The term 'community' - or town and village in Quebec - was preferred to 'city' in Canada to reflect both the inclusion of smaller communities that do not consider themselves 'cities', and the inclusion of self-defined communities or neighbourhoods within cities.) There are three largely or entirely provincially-funded initiatives, as described below. There is no national initiative; the Canadian Healthy Communities initiative that was established in 1989 had its funding cut in the recession of 1991/2.

- In Quebec, the Réseau Québécois de Villes et Village en santé (RQVVS) was established in 1990, and is closely affiliated both with the Institute National de Santé Publique du Québec (INSPQ) where it is based, and with Quebec's municipalities, who comprise its members and the majority of its board. Its mission is :

"promoting and supporting, through all Quebec, the sustainable development of the environment for healthy life. It focuses, with this intention, on exchanges and partnerships between municipalities, on the engagement of municipal decision makers in favour of quality of life, and on their capacity to mobilize their partners and their citizens for concrete action." (www.rqvvs.qc.ca/reseau/mission.asp)

It includes among its members 179 local or regional municipalities, (with one being a First Nation community) representing more than 50 percent of the population of Quebec. In addition to these formal members, it is possible for a regional public health service to work with a municipality, using a healthy

community strategy, without having the municipality joining the RQVVS, so the reach is broader than the formal membership; in fact, it is estimated that RQVVS has worked with 350 – 400 communities in the past 5 years (personal communication, Louis Poirier, Director, March 2009).

The 2008/09 budget for RQVVS is almost \$500,000 and comes mainly from the government of Quebec, via the INSPQ.

- The Ontario Healthy Communities Coalition (OHCC) is an incorporated registered charity, whose mission is *"to work with the diverse communities of Ontario to strengthen their social, environmental and economic well-being."* Established in 1992 and largely funded by government, it works to support local and regional groups, coalitions and networks that are working on Healthy Community initiatives in Ontario, but compared to RQVVS, is less focused on municipal governments. The OHCC supports multi-sectoral collaborations to strengthen local economies, deal with social issues and improve the environment, all with the ultimate objective of improving the health of the community and its members. (www.ohcc-ccso.ca/en)

As of September 2008 the OHCC had 376 members in 143 locations, including 80 'community members' from across Ontario (a community member is "a coalition of organizations that involves at least three community sectors, has adopted a Healthy Community approach and is working towards improving the social, economic and environmental well-being of their community"), 15 provincial organizations spanning the social, environmental, economic, and political spectrum, and 281 network members, including 4 organizations from other provinces. It is estimated that the OHCC has provided services to approximately 350 groups over the past 5 years (Personal communication, Lorna Heidenheim, Executive Director, March 2009)

OHCC's 2008/09 budget is approximately \$720,000, with about half coming from the Ontario Ministry of Health Promotion, and a quarter each from the Public Health Agency of Canada and the Trillium Foundation.

- The BC Healthy Communities initiative (BCHC) was established in the early 1990s but its funding was cut soon after. It re-emerged in 2005 with funding from the BC Ministry of Health through ActNow BC. Its vision is that *"All BC communities continually create and improve the social, environmental and economic assets that support health, well-being and the capacity to realize their fullest potential"* while its mission is *"to promote the Healthy Communities Approach, offering a shared platform for dialogue, collaboration, learning and action."*

BCHC supports communities and community groups that are taking a holistic and integrated approach to increasing health, well-being and healthy development in their communities through community facilitation, workshops, tool kits and small seed grants. Most of its current activities are on community engagement and capacity building processes, such as forums and

workshops, or small interventions to promote physical activity or healthy eating or landscape beautification. See www.bchealthycommunities.ca

It is estimated that BCHC has worked with more than 400 different organizations in some 300 communities across BC since it was re-established. Its budget in 2008/09 was just over \$550,000 from the BC Ministry of Healthy Living and Sport, with another \$50,000 in estimated in-kind contributions from the Union of BC Municipalities (UBCM), where it is located.

As can be seen, all three provincial networks take a broad approach that links environmental, social and economic factors together and they all facilitate and support collaborative action within communities. The Quebec initiative has a particularly strong focus on and link to municipal governments, while the Ontario initiative has a strong focus on community-based organizations and networks; the BC initiative, learning from the experience of its two senior partners, does both, being located, at UBCM but having a strong focus on community capacity building. All three have somewhat similar budgets and manage to reach, work with and support a large number of communities with what are really quite modest budgets.

4. Community engagement and capacity building

An early review of the WHO Europe healthy Cities Project (WHO, 1992) suggested the key building blocks for creating a healthy community are:

- community involvement
- intersectoral partnerships
- political commitment, and
- healthy public policy.

The strategic linking of these four key approaches constitute what could be described as a local strategy for improving population health and human development. Together, they strengthen and build – or to be more precise, build on – existing community capacity, or the assets that already exist in each community. Over the last decade asset-based community development has increasingly replaced the traditional needs-based, problem oriented approach to addressing specific health determinants. Each of these is discussed here.

4.1 Community involvement

The Tamarack Institute suggests that the process of civic engagement involves a five step process involving the following – and escalating – levels of involvement:

1. **Passive** – local residents and organizations are informed of issues by external organizations.
2. **Reactive** – Local residents and organizations provide input into the priorities and resource use of external organizations
3. **Participative**- Local residents and organizations influence the priorities and resources of external organizations

4. **Empowerment** - Local residents and organizations work in shared planning and action with external organizations
5. **Leadership** – Local residents and organizations initiate and lead, with external support, on issues.

Reminiscent of Sherry Arnstein's famed ladder of participation,¹⁶ this process becomes increasingly challenging to existing power structures as one moves up the ladder; but while this may be uncomfortable and challenging for some, it is empowering and liberating for the community and its members. Moreover, there is evidence to suggest that empowerment of individuals, which usually has a reciprocal and reinforcing relationship to empowerment of communities,¹⁷ is in and of itself good for the health of those who are empowered.

Such a process of empowerment is in fact the very essence of health promotion – “the process of enabling people to increase control over and improve their health”. And it is absolutely fundamental to the process of creating healthier communities. Of course, this tells us what needs to be done, but not how; that will be addressed later, in discussing the work of the Tamarack Institute and its Vital Communities program, and similar initiatives.

Suffice it to say that this process of community involvement is a long, slow process that requires and builds on small steps and growing trust and experience. As in so much else with respect to healthier, better communities, it takes time, and the development of local solutions to local conditions, not the imposition of a standard model. (Which is not to say there are not lessons to be learned from elsewhere, and principles to be applied, because there are. But the model is the process, not the specific details of a program.)

4.2 Intersectoral partnerships

This is an area where there has been, and continues to be, some confusion in our terminology. It is helpful to consider three different aspects of intersectoral action (Hancock, 2008):

- Inter-department/Inter-Ministry/ Inter-agency action (Figure 3a)

Action within an organization operating at any level from the local to the global (public, private, NGO etc) to link and coordinate action. Examples might include a Healthy City Office (as in Toronto) or an inter-departmental committee in a municipal government, a Cabinet Committee and program such as Healthy Child Manitoba, or a Healthy Workplace Steering Committee in a corporation. In government, this approach is often called a ‘whole of government’ approach.

¹⁶ Manipulation, Therapy, Informing, Consultation, Placation, Partnership, Delegated power, Citizen control

¹⁷ Always bearing in mind that in unhealthy communities, where the community uses its empowerment to exploit its weaker or more disadvantaged members, or other communities near by or remote from it, such community empowerment can be detrimental to the health of at least some, if not many others.

- Cross-sectoral action (Figure 3b)

Action with partners across multiple sectors (public private, non-profit, faith, academic, professional etc), operating at any level from the local to the global. Examples might include a broad-based healthy Community coalition, or BC's Healthy Living Alliance, which includes health NGOs, health professional associations, the Union of BC Municipalities, the BC Recreation and Parks Association, BC's health authorities and (ex officio) the Ministry of Health and the regional office of the PHAC, among others; however, it does not yet include the private sector.

- Vertical integration (Figure 3c)

Action across multiple levels. On occasion this may extend from the local to the global; more commonly it crosses some but not all levels. Examples include the Vancouver Agreement between the federal, provincial and municipal governments, or international coalitions of NGO focused on issues such as breast-feeding or tobacco control.

Figure 3a: Inter-department/Inter-Ministry/ Inter-agency action

	Government	NGO and Community	Academics	Private sector
Local	↓	↓	↓	↓
Regional	↓	↓	↓	↓
State	↓	↓	↓	↓
National	↓	↓	↓	↓
International	↓	↓	↓	↓

Figure 3b: Cross-sectoral action



	Government	NGO and Community	Academics	Private sector
Local				
Regional				
State				
National				
International				

Figure 3c: Vertical integration

	Government	NGO and Community	Academics	Private sector
Local				
Regional				
State				
National				
International				

All three of these forms of intersectoral action need to be operating if a healthy community/ community capacity-building approach is to be effective. First, there needs to be a commitment by municipal government to bringing key departments together so common approaches to cross-cutting issues can be developed. This in turn needs to be supported (as is seldom the case) by comparable structures or processes at the provincial and federal levels, so that such an integrated approach at the local level is supported by the actions of these higher levels of government.

Second, the work of creating a healthier (or better) community has to extend well beyond government, a ‘whole of society’ approach is needed. This also clearly needs to involve not just organizations but individual citizens, and is clearly linked to the community involvement strategies noted above. Many communities have found different ways to bring their many stakeholders together; the creation of a shared vision has been one powerful way in which common purpose can be found and common action taken, often over a period of many years. For example, the town of Rouyn-Noranda in Quebec, the first community in North America to formally declare itself a healthy community (in 1987) developed together with many of its young people a shared vision that continued to be a guiding light for many years. Similarly the healthy community initiative in the Township of Woolwich in Waterloo Region has been guided for some 20 years by a community vision developed in the late 1980s.

Third, there is a need not only for provincial and federal governments to support local action, but for a formal mechanism to be created that makes the three levels of government partners – but partners in meeting local needs, not partners in implementing national or provincial priorities directed at local issues.

4.3. Political commitment

While creating a healthier community is a larger task than local government alone can undertake, the role of local government is central to the whole process. High-level political commitment (from Mayors and Councils) has been a centerpiece of the WHO Healthy Cities Project, and in Quebec’s Villes et Villages en santé initiative.

At the same time, a different sort of political commitment is needed from provincial and federal political leaders: a recognition of the vital role played by local government in the creation of the conditions for health and human development, and a commitment to strengthen municipal governments in terms of their powers and resources, as will be discussed later.

4.4 Healthy public policy

Healthy public policy refers to the development of public policy in non-health sectors that is explicitly intended to improve the health of the population. The concept developed simultaneously with the concept of a healthy city or community (both emerged from the 1984 “Beyond Health Care” conference in Toronto). Thus one might ask at any level of government what would constitute a ‘healthier’ policy, be it for transportation or housing, urban development or parks, waste management or energy supply, agriculture or education, the economy or any other ‘non-health’ policy.

It was noted early in the development of the healthy city movement that it was at the local level that:

“ . . . the practice of healthy public policy is developing most rapidly and where its effects are most visible. There are clear reasons for this: many of the problems that have environmental or service dimensions are most obvious at the local level. So are the changes needed. Politicians at this level are more closely in touch with their electors and respond more clearly to their concerns. Governmental structures, even in large cities, interact more easily with each other

and find ways to coordinate their planning and action more readily than at the national level." (Kickbusch, Draper and O'Neill, 1990)

There are a number of characteristics that can make healthy public policy both more easy and more difficult to undertake at the local level. Local level characteristics that make healthy public policy more easy include:

- a degree of local intimacy among key actors in the smaller social networks and more human scale of the community
- policy makers (politicians and staff) live close to where they work and their decisions affect themselves, their friends, neighbours and family
- smaller bureaucracies may make response times faster and feedback easier
- closer links between the community and policy makers
- the possibility of linking community advocacy and community action directly to policy change and to policy makers.

On the other hand, some of the issues that make healthy public policy more difficult at the local level include:

- a number of "mega-issues", especially economic issues, may be nationally or even internationally determined
- local government may lack the jurisdiction or power to alter policy
- central government may be opposed to local initiatives and autonomy
- central government may dump on local governments, decentralizing the burden or responsibility for policy but not the power and resources to implement it
- local politicians may claim they are powerless to act, thus shifting blame upwards
- local jurisdictions (especially the smaller ones) may lack adequate resources and expertise. (Hancock, 1990)

To this list, one might add the challenge posed by the need to take a holistic approach to health determinants and not target single issues. But unfortunately our governments – at all levels - are not structured for a holistic approach and we lack people skilled in taking a holistic approach.

This last point needs to be elaborated on. Essentially in Canada, we have a system of local government that is based in the 19th Century; both literally and metaphorically. The origins of departments of public health, of public works, of parks, of planning and other municipal departments are found in the 19th century. They are set up on the 19th century models of separate sectors, of what we call today "silos". The problem is that most if not all the issues we face in the 21st century cut across these 19th century structures. The first response, because the old mechanisms no longer work for us, has been to create a lot of special purpose bodies, committees, task forces and work groups.

This proliferation is a symbol of the fact that the current mechanism doesn't work, the current structures don't work and so we have to create all these special purpose bodies. But this can only be a temporary response. Eventually, since the current structure is no longer capable of responding adequately to the challenges we will face in the 21st century, we will have to create new structures and processes of governance.

4.5 Asset-based community development

Starting in the mid-1970s John McKnight, a leading US community development practitioner and researcher, began to promote the notion of tapping into the positive facets of a community to leverage change, rather than focusing solely on a community's problems – to focus on the half-full rather than the half-empty glass, as he often put it, to recognize the strengths and capacities of a community's people, organizations and institutions and its physical assets.

McKnight's pivotal work, later summarized in the book "Building Communities from the Inside Out" (Kretzmann & McKnight, 1995) led to the development of the concept of "asset-based community development". Kretzmann and McKnight note that the traditional approach to finding solutions to issues such as homelessness, poverty, unemployment, crime and violence were always expressed in the negative as "needy, problematic, and deficient neighborhoods populated by needy, problematic and deficient people." This created a needs-based system in which outside experts and providers – government services, non-profit organizations, university researchers and other human service providers – came in to address the needs with specific programs and services. Kretzmann and McKnight noted that this approach was ultimately disempowering to the people of the community who become passive clients of services. This approach creates a victim mentality, promoting learned helplessness and hopelessness among the residents who began to see themselves as incapable of taking charge of their own lives or altering their community for the better.

This problem-oriented or needs-based approach, the authors noted, also creates other negative consequences:

- Fragmentation of services, each aimed at addressing a specific problem, rather than a holistic approach.
- Funding is directed to service providers, not to residents
- Weakening of community leadership and of community relationships. The most important relationships become that between the outside expert (social worker, health provider, funder) and the client, rather than between community residents.
- A deepening of the cycle of dependency – for funding to be renewed, for example, problems must continue and be worse than other neighborhoods. There is no real incentive to eliminate the problems.

Instead of focusing on needs and problems, John McKnight promoted an alternative path towards the development of policies and activities based on the capacities, skills and assets of lower income people and their neighbourhoods. By shifting to a capacity-oriented emphasis, communities take ownership of the issues. Kretzmann and McKnight noted that community development takes place only when local people are committed to

investing themselves and their resources into efforts of improvement. Communities are never built from the outside in or the top down, but from the inside out, or the ground up. Outside assistance is often required but this should be aimed at helping developing the communities assets. “Even the poorest neighbourhood is a place where individuals and organizations represent resources upon which to build,” the authors noted.

McKnight and Kretzmann have since founded the Asset-Based Community Development Institute at Northwestern University in Chicago. The institute is very active in research and publications on community development, produces practical resources and tools for community builders, and holds workshops on developing neighbourhood and community assets and networks extensively across North America. (See www.sesp.northwestern.edu/abcd/)

Over the last decade, asset-based community development has become an increasingly dominant model. Indeed, Inclusive Cities Canada and Vibrant Communities, described in the next section, both use this model to leverage change and engagement. The social planning councils, some of which have been in existence for nine decades and often functioned on the needs-based orientation, in teaming up with Inclusive Cities initiative are moving into this more positive orientation.

Text Box #4: Matching funds have changed Seattle's face

Two decades ago, Seattle launched an innovative program to promote neighbourhood innovation and community engagement.

Started by Jim Diers in 1988, the Neighborhood Matching Fund has since supported more than 3,000 community projects and award \$42 million in community grants. Neighborhoods have matched that contribution with \$65 million in cash donations, in-kind services and volunteer hours. In 1991, the Ford Foundation and Harvard's Kennedy School of Government named the matching fund one of the 10 most innovative local government initiatives in the US.

Over the last two decades, the program awarded as little as \$100 and as much as \$300,000 for neighborhood projects that included everything from beautification of streets and parks, community gardens, renovations to buildings, even oral history projects. The city now awards about \$2.5 million a year. Some of the most notable projects include:

- The Fremont Troll – The space underneath Seattle's Aurora bridge was a haven for drug dealers, the homeless and other undesirable activity. With money from the fund, artists from the surrounding community of Fremont built in 1991 a huge troll that clutches a real VW bug. The sculpture became a tourist attraction and is even used performance space for events like “Shakespeare on the Troll.”
- A popular mountain bike course was build underneath a freeway.
- A corridor of murals more than 2 km long was painted along Fifth Avenue, a busy commuter route
- A salmon-themed children's playground was built in a park and features an enormous salmon slide.

The matching fund projects typically bring together hundreds of people in the community, from construction workers, scout troupes, senior citizens, to artists and activists. The program has since been adopted by hundreds of communities worldwide.

Source: Harell (2009) ; Bhatt, (2008)

Jim Diers, a community developer in Seattle for more than 3 decades is another leading proponent of asset-based development and the author of *Neighbor Power: Building Community the Seattle Way* (Diers, 2004). On the faculty of the Asset-Based Community Development Institute as well as the University of Washington, Diers is now a leading authority on community building whose success with participatory democracy in Seattle is now being replicated in other centres. Diers recently authored a paper for the Canada West Foundation, *From the Ground Up: Community's Role in Addressing Street Level Social Issues* (2008).¹⁸ A summary of his larger book, he notes the only long-term solution to issues such as drug addiction, prostitution, homelessness and poverty is prevention through the building of strong and inclusive communities. This requires, however, that local citizens become engaged. Diers notes “People will get involved to the extent the effort is fun, shows results, utilizes the gifts everyone has to offer and starts where people are – their network, their passion, their block.”

The role for government and other agencies is to help build community capacity “in ways that fund and support community initiatives that are community-driven and builds on strengths. Two examples from Dier’s time in Seattle, as director of neighbourhoods are:

- A Neighborhood Matching Fund, which doubled the City’s \$45 million investment while involving tens of thousands of volunteers in completing more than 3,000 community-initiated projects since 1989 (see Text Box # 4)
- A Neighborhood Planning Program enabled neighborhoods to hire their own consultants and involved 30,000 people in developing 37 neighborhood plans between 1996 and 1999. Citizens subsequently voted for \$470 million in new taxes to help implement those plans.

Dier’s 2008 paper documented numerous creative ways that neighborhoods around North America have reduced, removed or prevented some of the leading social issues that undermine individual health and community wellbeing, by building networks and relationships, making inclusive neighborhoods, bringing in “labeled” individuals (drug addicts, prostitutes, the homeless) to be part of the solution – essentially having people work together for the common good.

However, one of the significant barriers to asset based development is that various levels of government and community agencies still tend to fund on a needs-based, problem specific model. Indeed, during key informant interviews this problem of the funding models for community development was continually raised.

Asset-based development is perhaps the key mechanism by which communities can build all five forms of capital, enhance personal

Key informants’ comments

“The way things are currently funded prevents an asset-based approach. It prevents taking time for reflection and building the relationships and understanding the dialogue necessary to move forward. Funders want to fund direct services into the community... Community building is not a direct service, therefore they don’t want to fund it. We have economic development corporations, why don’t we have a social development corporation”

¹⁸ www.cwf.ca/V2/files/CCI%20Diers.pdf

and community resilience, and improve the level of population health and human development. It has been an important aspect of the healthy communities approach in Canada from the outset, and is central to several other creative initiatives in Canada to maximise human and community development and wellbeing. As such, it needs to become central to federal and provincial government efforts to work in and with communities.

But as the next section also makes clear, a comprehensive and long-term process of asset-based community development does not just happen. It requires a long-term commitment to funding and in other ways supporting both the process and the community-based and community-driven supportive infrastructure needed at the community level.

5. New models of community governance for health and human development

Across Canada a variety of organizations, in addition to the three provincial healthy community initiatives, are attempting to address some of the determinants of health and human development through community capacity building and community engagement processes, largely to address issues like poverty, inclusion and active communities. Several of the leading national initiatives are profiled here, ranging from those in the nation's largest cities to an example from a small Aboriginal community. This is followed by a discussion of the emerging concept of 'healthy urban governance' and of the infrastructure needed for community governance.

Text Box # 5: Calgary Pursues Living Wage Goal Through Vibrant Communities

Over the last decade in the US, more than 130 communities have adopted living wage policies. A living wage is the amount of income an individual or family requires to meet their basic needs, to maintain a safe, decent standard of living in their communities and to save for future needs and goals. As part of its Vibrant Communities initiative, an action team with more than 20 partners is implementing a living wage campaign in Calgary.

The minimum wage in Alberta is \$8.40 per hour. Working a standard work week of 35 hours per week, 52 weeks a year, an individual without dependents employed at minimum wage would have a net annual income of only \$14,287 (including holiday pay). This income would be \$7,379 below Statistics Canada's 2007 (LICO) for an individual in a large city (\$21,666). Vibrant Communities Calgary's Living Wage Action Team has determined that an individual working full time (35 hours per week, 52 weeks a year) needs to make a minimum of \$12 per hour plus benefits (or \$13.25 an hour in lieu of benefits) to earn a Living Wage. Research shows 65,000 (10.8%) of employed Calgarians over the age of 15 earn less than \$12 an hour and women are disproportionately represented among these low wage earners, with 42,500 earning less than \$12.00 an hour.

Calgary's Living Wage Leader Program recognizes and rewards employers that pay their employees a Living Wage. In February 2009, the first business to receive the award was Calgary's Chamber of Commerce. In addition, Calgary City Council directed City Administration to develop Living Wage policy options to be applied to City staff and City service and to present an implementation plan for 2009.

Sources

Vibrant Communities Calgary Living Wage Fact Sheet
<http://www.vibrantcalgary.com/media/VCC%20Living%20Wage%20Fact%20Sheet%20May%202008.pdf>

Vibrant Calgary Living Wage program
 Website. www.vibrantcalgary.com/livingwage/

5.1 The Tamarack Institute and Vibrant Communities

The Tamarack Institute calls itself an institute for community engagement. Founded in 2002 by Paul Born and Alan Broadbent of the Maytree Foundation, the institute's mission is to assist citizens from different sectors of the community to come together and learn together to take leadership on issues that affect the whole community. Likening the effort to an old fashioned Amish barn-raising, Tamarack asserts that by working together communities can address and solve their local issues. A sense of well being arises from the levels of familiarity and trust that are built through contact, shared responsibility and support.

The Institute notes high levels of civic participation are linked to a community's higher overall quality of life. Communities whose citizens collaborate closely experience better educational achievement, better child development, safer neighborhoods, greater economic prosperity, and citizens with increased physical and mental health. But there first must be a community will – a clear sense that a community wants to take ownership of issues like poverty or health.

Tamarack notes that citizens can have a powerful influence and effect on the life of their communities. As such Tamarack has positioned itself to facilitate community engagement through a series of programs and services. One of Tamarack's key programs is Vibrant Communities, established in 2002. Vibrant Communities is a community-driven effort to reduce poverty in Canada by creating partnerships between people, organizations, businesses and governments. The program, supported by the Caledon Institute of Social Policy and the J.W. McConnell Family Foundation, now consists of 15 communities across Canada¹⁹. Vibrant Communities deliberately tests ideas about community building, poverty reduction, collaboration and engagement, and generates knowledge based on what works best in practice.

The work concentrates on five key approaches:

- Shifting the focus from efforts that alleviate symptoms of poverty to those that reduce the causes of poverty.
- Comprehensive local initiatives aimed at poverty reduction.
- Grassroots collaboration involving all sectors of the community in these initiatives.
- Identifying community assets and putting them to good use in poverty-reduction efforts.
- A commitment to learning, change and shared learnings – whether they are the product of successes or failures.

Although result of the Vibrant Communities are still preliminary, in an interview with founder Paul Born he noted that they are finding communities with creative local government and with citizens who become engaged and empowered can have a huge

¹⁹ Abbotsford, Calgary, Cape Breton, Edmonton, Hamilton, Montreal, Niagara, Saint John, St. John's, Saskatoon, Surrey, Trois-Rivières, Victoria, Waterloo Region, Winnipeg

ability to make meaningful social change. As one example, working in the Vibrant Communities process, citizens and government in Calgary were able to put in place a transit pass for low income citizens that cost 50% less than the regular fare. “This sounds small, but it is actually very big, because it is a philosophical idea that we haven’t been able to break in other cities in this country --the importance of transportation as a public good and that it is fundamental to the economy and to the employment infrastructure. That if people can’t afford transit, they can’t get to jobs at McDonalds.”

Other Vibrant Community actions have targeted child poverty in Hamilton, single parents in Saint John New Brunswick and affordable housing in Victoria.

5.2 Social Planning Councils and Inclusive Cities Canada

Across the country, municipal social planning councils, many of which date back 80 or 90 years, exist in many cities as community-based organizations that work on solutions to pressing social issues like homelessness, child poverty, food security, affordable housing, and immigrant support. Many of these organizations receive funding from groups like the United Way. As the Ottawa Social Planning Council website notes, its role is to address social issues and improve quality of life in Ottawa as “a unique one-stop resource for independent social research, community based planning, and community development support for individuals, organizations and networks creating positive change.”

A source linking all of the social planning councils in Canada is the Canadian Council on Social Development, a non-profit social policy and research organization, existing for 90 years, that focuses on issues such as poverty, social inclusion, disability, cultural diversity, child well-being, employment and housing. (www.ccsd.ca)

In 2003, a collaborative venture of five social planning councils²⁰ and the Federation of Canadian Municipalities formed Inclusive Cities Canada (ICC). They noted that social inclusion is recognized as a key determinant of health. Low income, poor housing, food insecurity all create feelings of social exclusion and, combined with a lack of participation in civic decision-making, creates ill health, higher rates of chronic disease and premature morbidity. Each city created a civic panel to document the inclusiveness of its city based on five dimensions of social inclusion:

- Institutional recognition of diversity
- Opportunities for human development
- Quality of civic engagement
- Cohesiveness of living conditions
- Adequacy of living conditions.

Inclusive Cities conducts research and engages local leadership and community participation in order to shape public policy and institutional practices. The goal is to create “a horizontal civic alliance” on social inclusion across urban communities in Canada. Social inclusion includes addressing isolating issues like poverty, homelessness, lack social support, immigration issues and more.

²⁰ Burlington (Halton County,) Edmonton, Saint John, Toronto, Vancouver/North Vancouver

5.3 The Vancouver Agreement

During the last decade new models of multi-level government cooperation have been emerging in the form of urban development agreements, the most famous of which is the Vancouver Agreement. The nature of some community issues are so complex that they call for new governance structures and new multi-networked partnerships.

Such was the case with Vancouver's Downtown Eastside (DTES) in the late 1990s. A public health crisis hit the low income, historic community in the form of an epidemic of drug overdose deaths and a spike in sexually transmitted diseases, particularly HIV/AIDS, syphilis and hepatitis C. High rates of drug addiction, mental health problems, crime, unemployment, poverty, and homelessness also plague the region. As home to some 16,000 residents, the DTES had disease rates that rivalled third world countries.

In March 2000, to respond to the economic, social, public health and safety challenges, representatives from three levels of government – the federal, provincial and city – signed a landmark agreement with a first phase lasting until 2005. It was renewed for a second phase in 2005, lasting until 2010. Each level was to contribute resources in terms of money, staff, and in kind services. In the first phase, the federal and provincial governments contributed \$10 million each as well as staffing resources and coordination from existing ministries and departments. The City of Vancouver contributed staffing costs, space in city buildings, zoning and building cost compensation, heritage preservation incentives and funding for capital projects such as renovation of old buildings.

Prior to the agreement, the three levels each were responsible for different pieces and acted on the issues separately and disjointedly, and people fell through the cracks. They did not collaborate nor coordinate services. The agreement recognized that coordinating services and expertise, and collaborating together on solutions with residents, community groups and business was the only way to address the complex intertwined problems of the DTES.

The agreement brought in a wide range of other community partners such as Vancouver Coastal Health Authority, local business and community agencies, as well as non-profit groups working in the DTES. Meetings are now held at a number of different levels with a variety of representatives from elected public officials to working groups of senior and mid-level public servants, to community representatives. The collective work of all the partners has the following overarching goals, as noted on the agreement's website:

- **Coordination** - increasing the coordinated efforts of the three governments and related public agencies towards desired outcomes in community change and action.
- **Innovation** - increasing innovation and creativity to achieve changes in how public agencies carry out their work together and in partnership with the private and non-profit sectors.
- **Policy change** -- identifying government and public agency policy barriers to effective community change and action, and removing or reducing these barriers.

- **Investment** -- increasing public and private investments (financial and human resources) towards desired outcomes in community change and action.
- **Monitoring and evaluation** - identifying key indicators as benchmarks to monitor progress and concrete accomplishments.

In pursuing these goals, the Vancouver Agreement focuses on five strategies:

- Facilitate forums and intergovernmental task groups.
- Initiate joint public agency planning processes.
- Support learning through information sharing, research, evaluation and progress monitoring.
- Conduct research into effective approaches and evaluation of joint public agency projects and make recommendations to enhance effectiveness.
- Invest funds in specific public agency projects and lever additional financial and human resources through partnerships with the private sector.

The agreement had four major desired outcomes from all these coordinated activities and increased commitments in time, money and expertise. These desired outcomes were:

- Improved health outcomes for local residents, reflecting increased choices and ability to meet basic needs.
- Improved safety and security and addressing the negative impacts of crime.
- Growth in the numbers, size and diversity of local businesses, and diversified employment opportunities for local residents.
- Improved and increased housing options, including affordable rental, supported and transitional housing.

During the first five years a number of significant changes were accomplished, including:

- **Improved health outcomes:**
 - a significant reduction in death rates due to drugs, alcohol, suicide and HIV/AIDS infections.
 - better access to primary care services with the opening of new health clinics.
 - the opening in 2003 of the first supervised injection site in North America – a highly controversial project that in research studies has been shown to reduce the harm of injection drug use and increase uptake of treatment.
 - the creation of more detox beds, youth detox and drug treatment resources, including an onsite treatment program at the supervised injection site and the expansion of methadone treatment.
 - centralized telephone referral services for access to detox facilities for youth and adults.
- **Crime reduction:** Property crime decreased by 14 % between 2000 and 2005.

- **Growth in business and employment opportunities:**

- Job training programs and employment support increased for the unemployed in the area, including those with drug addiction and mental health issues.

- **Improved housing options:**

- The completion of 53 development projects between 2000 and 2005 including 9 subsidized housing buildings, 12 market housing developments, three mixed use developments with daycares, commercial space and housing, and a number of health related facilities. One showcase development is the Woodward Building. (See Text Box #6)
- The renovation and upgrading of single room occupancy hotels, starting with the Silver and Avalon Hotel in 2005.
- The creation of 911 more subsidized housing units in 5 years and 259 more beds or living units for those who are seniors or who have mental health issues or disabilities.

In March 2005, the three levels of government renewed the agreement for another 5 years. In June of 2005 the Vancouver Agreement was one of eight recipients of the United Nations Public Service Award, taking top prize for transparency, accountability and responsiveness in the public service.

Text Box 6: Woodward Building brings mixed-use innovation to DTES

From 1903 Vancouver's famed Woodward Building, with its huge neon W, has been a dominant structure in the downtown eastside. The department store's closure in 1993 greatly contributed to the exodus of business from the DTES. Over the next decade, many plans for redevelopment failed and the empty, decaying structure, home to squatters, was symbolic of the complex problems of the DTES.

The building was bought by the provincial government in 2001 for \$22 million, and then sold in 2003 to the city for \$5 million. Then a unique community consultation process took place. The result of the extensive process is Canada's (and perhaps the world's) first highly diverse array of mixed use on one site and is key to the revitalization of the DTES.

Of the 546 units, 125 are single, non-market affordable housing with design features like wall mounts to hang bicycles. The remaining suites are market units, that vie with any of Vancouver's downtown condos and which sold out in eight hours. Also on the site are popular retailers (London Drugs, Nesters Food Store) the western offices of the National Film Board, and Simon Fraser Universities new Centre for Contemporary Arts, including five performance venues. The building, which includes the restoration of the oldest heritage structure, will also house office space for community non-profits.

"Its diversity is unparalleled," said architect Gregory Henriques, who calls it a "huge, exciting social experiment."

The first tenants are expected to move in by June 2009. And when the entire project is completed, the crowning touch will be the replacement of the huge neon W – refurbished and safely stored for the past years – so it can once again dominate the skyline and celebrate a landmark structure.

More information.

<http://vancouver.ca/bps/realestate/woodwards>

Based on the success of the Vancouver Agreement, other municipalities with significant social issues like drug use, homelessness and poverty, such as Victoria BC, began talks to model an urban development agreement for their region among the three levels of government.

However, following the January 2006 election which changed the federal government from Liberal to minority Conservative, sources say the Vancouver agreement for all intents and purposes lost effectiveness. The agreement still exists on paper and is still touted as a model of unique multi-level collaboration. However, since 2006 there has been no updating of what used to be a very dynamic website. There has been no press release issued since spring 2006 nor any updating of outcomes, nor any updating of the financial commitments. While no one will go on the record about new investments, it seems that while the provincial government has given a further \$8.5 million, no further money has come from the federal government. In addition, in 2006 a number of key staff left the Vancouver Agreement for new jobs, including the first executive director and the head of media relations. Important revitalization work continues in the DTES with the provincial and municipal government and local agencies and non-profits, but the federal involvement under the agreement has apparently dwindled.

At the same time in Victoria, late in 2006, the negotiations for a Victoria Agreement gradually fell apart and the initiative stalled. While officially it is being stated that the agreement is being postponed, many key officials, such as the project manager have left for other jobs.

The initial success and the subsequent apparent (but not publicly official) stalling of the Vancouver Agreement illustrates a key barrier to these complex, multi-level agreements: they are intensely vulnerable to changing political winds. With three levels of government there are three times as many political agendas, three times as many potential changes of government, and three times as many ways the work can be sidetracked or halted.

The issues of the determinants of health are long-term, societal issues that need to transcend politics and outlast four year political terms. Results often will not be seen for years, so there has to be some consistent, stable way to keep the focus and efforts on promising initiatives. As the next section details, barriers to this type of work abound.

5.4 Oujé-Bougoumou – An inspirational Aboriginal community

Ouje-Bougomou is a Cree community of about 650 people in northern Quebec. The astonishing story of their journey from a dispossessed and marginalised community in the 1970's to an empowered community that is today a model of sustainable human development is inspirational! The community personifies Margaret Mead's famous remark - "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has." The people of Ouje-Bougomou have not only immeasurably changed their world, they have inspired others to see what is possible in their own communities, and have thus changed the wider world.

A summary of their accomplishments is shown in Text Box #7; a more detailed description can be found at the community's excellent website - www.ouje.ca/

Text Box # 7: The story of Oujé-Bougoumou

Selected excerpts taken from the community's website at www.ouje.ca/

" . . . we undertook a dramatic and remarkable journey from the squalor and marginalization most usually associated with the Third World to an optimistic and forward-looking model aboriginal village." – Chief Sam Bosum

Our People

The Oujé-Bougoumou people are the community's greatest resource. Every person here has a wealth of life experiences and an amazing story to tell.

Our elders had a vision: a community for their children and grandchildren. This vision sustained them in their struggle to see their dream become reality.

The elders of the Oujé-Bougoumou Nation have given us so much: they have given us the benefit of their wise counsel; they have preserved our sense of community in the face of tremendous odds; they have given us the courage to continue our struggle; and they have given us a sense of perspective and direction whenever we needed it. It is perhaps the younger generation that will be the builders of the village, but it is the older generation who have been the protectors and defenders of our community.

Our Youth

When we talk about developing the skills and obtaining the education required to build our community, to make it viable, to achieve our goal of self-sufficiency, we are really talking about our youth.

It is the youth who will have the real opportunities to acquire advanced educations and very specialized training in those areas which will contribute to the well-being of our communities. In a very real sense the future of our community belongs to our youth.

Our Vision

When we began to seriously plan our new village, we started with a vision. The essential thrust of that vision was to re-create the well-being of our traditional way of life to the fullest extent in the context of modern facilities and contemporary institutions.

Major Objectives

In planning the new village, we defined three major objectives:

- Our village had to be constructed in harmony with our environment and with the traditional Cree philosophy of conservation.
- Our village had to provide for the long-term financial requirements of our people.
- Our village had to reflect Cree culture in its physical appearance and in its functions

We realized quite early on that if we were successful in realizing our vision, then our entire village would become a kind of healing center in which healing is viewed as much more than simply the remedying of physical ailments. If we could structure our new village and our new environment in such a way as to meet all of the varied needs of our people then the result would be a place which produced healthy, secure, confident and optimistic people who felt good about themselves and able to take on any challenges which may confront us.

Text Box # 7 – Cont.**Innovation in the Design of a New Community**

The following are some of the key elements in the physical and social design developed by the people of Oujé-Bougoumou.

Design and Architecture

If the people of Oujé-Bougoumou feel empowered by their new home, it is because they played an intimate part in its inception, creation, and construction, and because the village is a living reflection of their culture and lifestyle. Canadian Geographic (July/August 1994) labeled the new community "an achievement never before seen in Canada - a native settlement with architectural coherence and integrity".

- Housing Program
- Alternative Energy Program
 - District Heating System – Heating Plant

On the Road to Self-Reliance

- Economic Development
- Harmony with the Environment
- Forest Resources
- Cultural Tourism
- Development of Community Crafts and Other Small Industries

Community Services for Social Development

- The Healing Center
- Alternative Justice

Preserving Our Cultural Identity

The communities of the Cree Nation of Eeyou Astchee, guided by their elders, have decided that there will be a building to be located in Oujé-Bougoumou which will house all the existing agencies which currently provide programming in the areas of culture and language preservation. There will additionally be facilities for exhibiting historical artifacts and art reflecting Cree culture. In Cree, the new Institute is called Anischaugamikw which means "the handing down from one generation to the next".

5.5 Healthy urban governance

The WHO Commission on the Social Determinants of Health established a number of 'Knowledge Networks' – groups of experts from around the world, one of which was on Urban Settlements. Although focused largely on the plight of the 1 billion people worldwide living in slums and informal settlements, the Knowledge Network's discussion on

how urban governance should be organized so as to improve the health of the population is also applicable to cities in more developed nations such as Canada.

Key extracts from the Report of the Knowledge Network on Urban Settlements are shown in Text Box #8.

Text Box #8: Our cities, our health, our future: Acting on social determinants for health equity in urban settings

Report to the WHO Commission on Social Determinants of Health from the Knowledge Network on Urban Settings - Prepared by the WHO Centre for Health Development, Kobe, Japan - **Chair and Lead Writer:** Tord Kjellstrom

http://www.who.int/social_determinants/resources/knus_report_16jul07.pdf

Healthy urban governance

The WHO Knowledge Network on Urban Settlements, established by the WHO Commission on the Social Determinants of Health, refers to “healthy urban governance”, as the systems, institutions and processes that promote a higher level and fairer distribution of health in urban settings, and as a critical pathway for improving population health in cities. Key features of healthy urban governance are:

- Putting health equity and human development at the centre of government policies and actions in relation to urbanization.
- Recognizing the critical and pivotal role of local governments in ensuring adequate basic services, housing and access to health care as well as healthier and safer urban environments and settings where people live, work, learn and play.
- Building on and supporting community grassroots efforts of the urban poor to gain control over their circumstances and the resources they need to develop better living environments and primary health care services.
- Developing mechanisms for bringing together private, public and civil society sectors, and defining roles and mechanisms for international and national actors to support local governance capacity.
- Winning and using resources – aid, investment, loans – from upstream actors to ensure a balance between economic, social, political and cultural development and establishing governance support mechanisms that enable communities and local governments to partner in building healthier and safer human settlements in cities.
- Appropriate feedback mechanisms for communities to report their satisfaction or dissatisfaction with the interventions are needed to promote community empowerment and ownership and ensure each community’s priorities and unique needs are considered. (p 18)

Two other key elements identified later are:

- Higher levels of government providing local governments with both the mandate and the means to improve health;
- Participatory budgeting and other civic engagement processes as important means to engage the local community. (p 50)

Text Box #8 – Cont

The WHO Knowledge Network on Urban Settlements suggests the following elements for building good governance:

1. *Assessing the urban context*, as in evaluating the current equity issues in urban health and health impacts, the prominence of urban health equity in the government's policy agenda, and the timing and urgency of implementation of the underlying urban health policies or strategies.
2. *Identifying stakeholders*, as in clarifying the people, groups, and organizations that have interest and control of urban health impacts.
3. *Developing the capacity of stakeholders to take action and build social capital and cohesion*, because action on policy change requires that sufficient knowledge, skills and resources are in place.
4. *Assessing institutions and creating opportunities to build alliances and ensure intersectoral collaboration*, since it is institutions that determine the frameworks in which policy reforms take place.
5. *Mobilizing resources* necessary for social change. This may require better redistribution of resources.
6. *Implementation including strengthening the demand side of governance*: assessing and ensuring people's participation from the organizational and legal perspective, taking into account the issue of access to information and data that can ensure social accountability.
7. *Advocate for up-scaling and change* of policy and advocacy to relevant stakeholders at different levels
8. *Monitoring and evaluating of process and impacts* including opportunities for setting up systems for monitoring at an early stage. (p 39 – 40)

5.6 Creating an infrastructure for urban governance

Sherri Torjman (2007) argues that the core task of the 'communities agenda' is to improve links among key players, across key sectors, and between communities and governments. In a chapter entitled "Organizing for complexity" she argues that the key task is to establish a multi-sectoral local decision-making process that develops a comprehensive and long-term plan that addresses the community's problems by building upon existing strengths and capacities (p33).

However she notes (as do others, see key informants comments) that

"There is a serious governance gap - a mis-match between the complexity of local challenges and the corresponding problem-solving capacity." (p 40)

Moreover she notes that community governance is broader-based, more diverse and tends to have a longer-term vision in place than does municipal government, which is both a strength and a challenge.

Such community governance processes and structures, in taking a long-term and comprehensive approach, seek to counter the short-term, fragmented approach that is all

too common in programs and funding provided by governments at all levels and by many philanthropic funders. Torjman argues that such “fragmented responses cannot possibly work well in a world in which all the components are intrinsically linked”, that they are too seldom holistic or preventive, and “because they often assume that governments alone can solve problems” (p’s 43-4).

An important point with respect to the new community governance structure, Torjman argues, is that they call for a new style of leadership, with leaders who focus on building relationships, networks and trust, developing shared vision and understanding, and sharing credit with others. Such leadership skill can be and need to be taught.

Torjman also notes that these community governance structures require significant commitments of time, energy and resources, which means they need to be well supported over the long term. Yet at the same time they have to demonstrate short-term action and success, within the context of their larger plans, if they are to attain and build credibility with the community and the funders.

These are all lessons learned long ago by social planning councils, healthy community projects and many others working on what Neil Bradford calls the ‘wicked problems’ of long-term, complex challenges to community resilience and human wellbeing. The creation of new community governance processes and structures calls for a very different approach on the part of both government and philanthropic funders

6. Barriers to community governance and action for health and human development

So if it has been clear to many working on the ‘communities agenda’ for many years that new processes, new structures and new funding arrangements are needed, why have these changes not occurred in a large scale across Canada? The loss of political commitment, as apparently occurred in the Vancouver Agreement, is just one of the potential pitfalls of community-based action on health and human development. Research as well as interviews with several key informants²¹ familiar with these and other national efforts to develop a broad-based communities agenda within Canada identified a number of barriers to taking a stronger, more community-based approach to improving the level of health and human development.

6.1 A fragmented approach to community issues – and the need for a more comprehensive approach

One of the most common themes that emerged both from the literature (see for example section 5.6) and from the key informant interviews is that the present fragmented, silo-based approach to community issues is not working. As one key informant put it:

“We say that ‘everything is everything’. It is all interrelated. You can’t create a vibrant community by focusing on one thing. Everything is done by projects, but the reality is that we need to be thinking in the context of a whole system”

while another noted that

²¹ A list of the key informants interviewed is in Appendix 3

“It really is a piece of work in itself, the decision making, the planning and making sure that everything is kept on track. When you are trying to put together a complex initiative that is bringing in pieces, and an integrated initiatives where you want to ensure that the pieces are working together. There is a lack of support for that integration of decision making, in itself.”

6.2 Absence of a comprehensive national vision

As noted in section 5, a number of new initiatives are using collaborative or asset-based approaches to deal with health determinant issues. While individually, all these organizations are doing good work in their respective communities, the weakness is that there can be a duplication of effort. Of more concern, it appears that there is a lack of a single comprehensive vision of the role and function of the community, on the part of either the provincial or federal governments. This means that only too often there is a lack of support at the national or provincial levels for a comprehensive and empowering approach that would support the community to identify its own problems and develop its own solutions. One example of the lack of infrastructure support at the national level, for example, is the nature of regulations limiting the activities of charities, as described in the next section.

One of the related themes that arose is that the Canadian focus on the acute care health system is actually to the detriment of community based initiatives to improve the health of the populations, not only in terms of government focus, but by the sector that works in the health field. As one key informant noted:

Key Informants' comments on a shared (national) vision

“We have a federal government that has not truly embraced politics and policies towards the social sector or the civil society.”

“Our conclusion is that we need to organize ourselves differently. . . . We need to keep doing what we are doing, but we have to have a common vision for what we want to be and then we have to find a better way of working together to achieve that vision and see ourselves as serving that vision instead of a 100 different visions.”

- “People in health have not adequately thrown their weight behind those in the social sector. They may clean up the mess of what society has done to individuals but they don’t seem to walk the preventative talk with us, and to powerfully support decent housing, poverty reduction strategies, etc. What I see right now happening in our communities - the real work on health is often occurring outside of health, in civil society, in social agencies for example. The two aren’t talking. I think that is a tragedy. Those of us in health and the social sector, have to look at the issues as comprehensive, as dynamic. We have to look at the interrelationships between the social, the economic and health. Anything less isn’t good enough anymore.”

6.3 Outmoded municipal arrangements

A number of writers, academics and organizations have noted in recent years that constitutional and fiscal arrangements with municipalities need to change in order to address the increasingly complex issues of urban society.

Judith Maxwell, president of the Canadian Policy Research Networks wrote in 2006:

“Local governments face all the complex challenges and opportunities of the 21st Century but are forced to operate with the legislative and fiscal powers of a 19th Century constitution. In these conditions, their only hope is visionary leadership, a fully engaged citizenry and responsive senior governments. They need the kind of leaders who can make change happen – not just in local government but across the community – in business, education, non-profits and in citizen and community groups.”²²

Neil Bradford, a professor of political science at the University of Western Ontario and a research associate at the Canadian Policy Research Network has frequently written on the new deal that is needed for municipalities (Bradford 2002, 2004, 2007). He notes that Canadian governments must overcome constitutional hang-ups, political rivalries and outmoded fiscal arrangements to collaborate on a new urban agenda. Bradford states it is the only way the Canadian economy can compete with other global cities that deliver a high quality of life to their citizens (Bradford, 2002).

Bradford argues that the increasingly complex challenges that govern the quality of life in our cities cannot be solved by one or two players acting on their own. Instead, traditional, segmented and silo approaches must be set aside in favour of “place-based public policy” rooted in “collaborative, multilevel governance.” This requires a new urban policy framework that recognizes the complexity of policy problems, that taps into *local knowledge and resources*, and is characterized by *horizontal collaboration* within cities and communities, and *vertical collaboration* across all levels of government – like the Vancouver Agreement, but one that is able to exist over the long term. (Bradford 2007)

The Federation of Canadian Municipalities (FCM) also has a number of policy statements urging a new arrangement with the provincial and federal levels of government. In its policy statement on municipal finance and intergovernmental arrangements (FCM 2008) the FCM notes there is a growing gap between the services Canada’s municipalities must deliver and what they can afford. Compared with other orders of government, Canadian municipal governments have far fewer tools with which to raise revenue. Municipal governments in the United States and other OECD countries have more diverse, generous and flexible ways to raise funds than those available to Canadian municipalities.

The FCM policy statement notes that a 2002 report on Canada by the OECD concludes that Canadian municipal governments’ heavy reliance on property taxes lies at the root of their growing fiscal difficulties. The report also states that Canadian cities have “relatively weak powers and resources” and should be given “some limited access to other types of taxes” to meet their increasing responsibilities. Out of every tax dollar collected in Canada, municipal governments get just eight cents (principally from property taxes), while the other 92 cents goes to the federal and provincial governments.

It also notes that over the last 10 years, provincial and territorial governments off-loaded responsibilities to municipal governments without transferring adequate financial resources. Municipal governments now deliver programs that support immigration, the environment, Aboriginal peoples, affordable housing, public health and emergency

²² As quoted in *Toward the Tipping Point: Aligning the Canadian Communities Agenda*, pg 11. Available at <http://www.ccl-cca.ca/NR/rdonlyres/301F7CD2-2EF6-4914-9CB0-40E3AD42C100/0/2007091920TippingPoint.pdf>

preparedness and public security with no increase in funding. In addition, over the last decade transfer funds have not kept up with the cost of living or these increased responsibilities. The FCM notes from 1999 to 2003, federal government revenues increased 12 per cent, provincial and territorial revenues 13 per cent, and municipal government revenues only eight per cent. In 1993, transfers accounted for 25 cents of every dollar of municipal revenue; by 2004, they accounted for only 16 cents, a 37 per cent decrease.

The solution, the policy statement notes, is a different constitutional arrangement and more leeway to raise funds, such as through a portion of the sales tax, a portion of the income tax, gas taxes and user fees.

6.4 Lack of a community infrastructure for governance

This is the inverse of the need for a process and structure for community governance that was discussed in section 5.6. As one key informant noted:

“Funders don’t want to fund process [because they feel] you don’t get anything out of that. But it is saying that we can have policy without having any debate in the House of Commons. That they would just go and produce policy and that there would be no committees, there would be no deliberation, just go and produce a policy. It is the same in communities. It would be saying, go and do your programs, and we don’t have time for you to come together to do your planning or to do any assessment.”

6.5 Funding limitations

Since so much of the current activity in community based health promotion and community development is being executed by registered charities, the issue of access to stable funding is a constant problem. The recent economic downturn has placed even more pressure on chasing limited funds. Most granting family and community foundations in Canada have lost up to 30 % of the value of their endowments, which greatly limits their ability to provide grants. Private donors are also experiencing a shrinkage in the value of their assets that they can donate to worthy causes. Government grants are also shrinking and often require a project-specific focus and do not support the asset based model for planning, for processes such as meetings and community engagement, as these are not specific services or programs. There is funding for pilot projects, but if the pilot proves successful there is no funding for wider implementation. The need to constantly be applying to grant programs or foundations can eat up a huge amount of time and activity that does not ultimately address the community issues at hand. Funding pressures can prevent cooperation and collaboration in community development taking place because organizations are competing for the same funds.

But beyond the problems with levels of funding, there was a larger concern with the current approach to funding among our key informants. They were concerned that funding too often was fragmented, short-term and bottom down, and this is reflected in their many comments about these concerns.

Selected key informant comments on funding

"Funding pits people against one another. It actually destroys certain social relations. People are after the money."

"The federal role' then it needs to be able to give flexible funding formulas, so that "if this is the money that we are giving toward health, how can we allow communities to be more creative with this money?"

"There are not the funds available to typically support a decision making body or governance structure, or a local table, whatever you call it, that comes together and makes decisions around the comprehensive approach that they want to develop. So often times the community is left to support that process itself. Unless they can find some financing for it, or somebody to give a staff person to devote some time to it, it typically flounders without that ongoing assistance."

"The money that tends to be available goes towards shorter term, individual projects, that are rooted in single departments, single ministries. If you have an integrated approach that crosses over and involves a number of departments, it is often difficult to get any funding for that. You get each department funding its own piece. I know, having been involved in a number of projects that have tried to move beyond that single, government approach, we have always been pulled back into that very traditional vertical model."

"All is not rosy in the world of multi-network partnerships. The public decision maker still wants a lot of control over the money he/she devolves. It is still passing the money to fulfill a mandate that is a public mandate. There is still a lot of control. The evaluation of those programs that are based on public funding devolution to community organizations, the issues around the evaluations around those programs are huge, and most of them are conflicting....If you tag the money to specific projects, from the regional to the local, then you are handcuffing the people and you are in for an interesting political fight."

"Five different federal departments came together to work on this neighbourhood renewal approach. They basically said, "we want it to be citizen oriented and community driven." At the same though, each of the branches was basically saying, "but we want you to do something in the area that we are interested in. How many drug abusers have you dealt with? And Literacy wants to know what we had done for literacy." So there was a contradiction in terms. "Yes, let the community define what it is that they want to do," but at the same time the government is saying, "however they have to work on XYZ, that is just of interest to us."

"There are tremendous problems in terms of the funding, the accountability, the long term time frame that is required. They typically have short term kinds of initiatives in place."

"Philanthropic funding, undermines social development. Philanthropic funding does not accept a framework of say, Healthy Communities or social determinants of health, or inclusion. That is not a direct service. They are not interested in preventing, why people are there, or understanding. They are just interested in providing a service. . . . Intermediary organizations they don't wish to fund. Or processes. Or research and development."

6.6 Lack of consensus on support for more universal programs

A number of key informants noted that community-based population health promotion and human development would be much more effective if there was a baseline of universal programs to deal with key health determinants across the country. Then community –based health promotion activities could be built on top of that solid foundation. The World Health Organization, in its 2008 report on the social determinants of health, noted the Nordic countries provide much greater support for universal programs and as result have less social inequity and fewer health problems caused by inequalities in access to the determinants of health.

In particular there is widespread agreement in a number of recent reports on population health and its determinants that early child development is a fundamental building block for health and human development and that there is a need for high quality universal child care programs that support early childhood development and education for all Canadian children regardless of their family's income.

But Torjman (2007) cautions that

“The communities agenda in no way minimizes the need for a solid core of public goods and services. Community-based actions both supplement and complement – but do not replace – public policies focused upon economic and social wellbeing.” (Torjman, 2007, p3)

Selected key informants' comments on universal programs

“That is the risk in community based programs, that we lose sight of the importance of having universal programs.”

“There is a basic conundrum of those issues in Canada. It amounts to ‘How can we promote answering local needs, while at the same time, promoting a Canadian basket of services?’ How to be fair and treat all Canadians the same, whereas attending to local needs? I don’t think we have totally succeeded in finding an appropriate answer to that in Canada.”

6.7 Limitations of federal charity regulations and social investment

Most, if not all the non-governmental organizations doing work at the community level on health determinants are registered Canadian charities. They receive a large portion of their funding – often more than 80 % -- from family or community foundations and private donors. The Canadian Revenue Agency (CRA) regulates registered charities through the *Income Tax Act* and all registered charities must operate in compliance with the law. Yet an outdated Income Act now hampers innovative work by the charitable sector on social issues and community enhancement. Interviews with key informants also raised the issue of the rigid and outdated charity regulations as

Key Informants' comments on charity regulations

One key informant noted that the laws surrounding registered charities restricts the range of activities of one important national program, which has 85 % of its funding from philanthropic foundations. She/he said they had to work with Revenue Canada to allow exceptions to some of these rules in their community work, particularly to allow them to create benefit to individuals by reducing poverty.

hampering innovation and service delivery.

In a lecture entitled “Unleashing the Power of Social Enterprise”, former Prime Minister and Finance Minister Paul Martin called for an overhaul of the Income Tax Act in particular to encourage social innovation, social enterprises and entrepreneurship, and community investment: “There is now a problem with the historic boundaries [the Income Tax Act] sets out in that they have not kept pace with the evolution of the social domain they seek to serve” (Martin, 2007).

Martin is particularly interested in promotion of economic independence among Aboriginal Canadians by supporting and mentoring Aboriginal entrepreneurs with investments that may have a below market financial return but a high social return. “The fundamental problem is that in Canada there is a very clear division between charitable giving on the one hand and private sector investment on the other.” Martin noted the rigid line between charitable giving and social enterprise operates to the detriment of Canada’s social goals.

A recent paper, *Canadian Registered Charities: Business Activities and Social Enterprise – Thinking Outside the Box* (Carter & Man, 2008) notes that the CRA does allow some social enterprise under its guideline RC413(E) - Community Economic Development Programs - but what is permitted is “extremely restrictive and falls short of the broad social enterprise activities that are being conducted across the global landscape.”

Some examples from the global community include:

- The US now allows foundations to make investments in social enterprises out of endowment funds without affecting charitable status. These Program Related Investments (PRIs) are allowed if the primary goal is social return. Vermont and North Carolina allow the regular investors, not just foundations, to invest in social enterprise endeavors through charities.
- The US introduced New Market Tax Credits as part of the Community Renewal Tax Relief Act of 2000. The New Markets Tax Credit Program will spur approximately \$15 billion in investments into privately managed investment institutions called Community Development Entities (CDEs) that make loans and capital investments in businesses and individual enterprise in underserved areas. By making an investment in a CDE, an individual or corporate investor can receive a tax credit worth 39 percent (30 percent net present value) of the initial investment, distributed over 7 years, along with any anticipated return on their investment in the CDE.
- In 2005, the UK created a new form of corporation, called a Community Interest Corporation (CIC), which is an organization that conducts a business with the purpose of benefiting a community rather than purely for private gain. CIC’s must meet a “community interest test” and “asset lock”, which ensure that the CIC is established for community purposes and the assets and profits are dedicated to these purposes. Registration of a company as a CIC has to be approved by the Regulator who also has a continuing monitoring and enforcement role. In March

2009, there were 2578 registered CICs in the UK²³ and the numbers increase by at least 100 a month.

Imagine Canada²⁴, a charity that speaks on behalf of the Canadian charitable sector notes that Canada has 161,000 registered charities and nonprofits, which marshal more than 12 million volunteers and 2 billion hours of volunteer time. They employ a workforce of 2 million full-time equivalent workers --11% of the economically active population -- which accounts for 8.5% of Canada's GDP. Many of these charities are working towards social equity, community enhancement or other activities that increase social capital. This is fertile ground for the Canadian government to explore new legislative mechanisms and tax incentives to support and tap the passion and commitment of this sizeable workforce to address the determinants of health.

6.8 Burn out of volunteer sector

Much of the community-based activity is driven by charitable organizations that depend on the passion and commitment of volunteers. But the work is not easy. It often deals with helping people and communities that have severe social problems. The stress level is high and social interactions can be challenging. The economic downturn puts even more stress on the volunteer sector as more Canadians find themselves without work or facing financial crises. Burn out and high turn over is common.

Key informant comment on burn out

One key informant noted that the current economic downturn is making burnout even more likely: "Those of us that work in the sector know that we can't cope with the needs that people will have. So there is a desperation to that. You know that you don't have resources both financial and human. As people bleed from the sector, we are going to be left without the people that can best do the work. I think it is really quite a moment of despair...You are kind of overwhelmed by the stories."

6.9 Problems sharing Canadian successes

Key informant comment on sharing

"As Canadians we have not supported, much to our detriment a pan-Canadian movement. It is costly to share across this land. And we haven't supported it. Most of all, we have not been able, in English Canada, to access easily some of the marvelous things that happen in Quebec."

Another barrier to effective community development and engagement on social determinants is the nature of Canada itself. The geographic size, the language issues and the various provincial silos mean that often promising developments and initiatives in one province are not shared in other regions. In particular, both in the research of this paper and in the key informant interviews it was noted that finding out what is happening in Quebec, if you are not bilingual, is very difficult. Likewise a

francophone organization would have a hard time accessing information about successful community programs in English Canada.

²³ For more information on CICs visit www.cicregulator.gov.uk

²⁴ See newsrelease at

http://www.imaginecanada.ca/files/en/publicaffairs/budget_2009_response_release_20090127.pdf

7. Integrated community-based human services

An important subset of community-based human development is community-based approaches to integrated human services. Community-based human development is the overarching umbrella of actions at the community level that makes people's lives better, and that improve health determinants. Integrated human services are one way of addressing human development and influencing health determinants by coordinating the actions of individuals and services. The concept is to provide services to the public that streamlines and simplifies client access, increases efficiency, provides superior care and bridges traditional organizational or program boundaries.

Integrated human services are often described as 'one stop shopping', seamless service so that individuals only need to tell their story once. It is a process of breaking down traditional silos, working across boundaries and coordinating efforts in service to the client. While this model is a "problem-oriented" approach and not an asset-based approach, as described earlier in the document, the goal is always to work in partnership with the client and to empower them by removing barriers and creating straighter pathways out of poverty, ill health and other dysfunctions.

Of course, human services alone, even if well integrated, do not make a community healthy. But many people with health and social problems and human service needs find the current system complex, disjointed, uncoordinated and frustrating, and this is made worse when one considers that many of those with the greatest needs, and with needs for multiple services, are from disadvantaged groups.

So one part of an overall, community-based approach to health and human development should be the integration of human services, wherever possible, and where it makes sense for the users.

Examples of integrated human services include Quebec's CLSC's (centre local de services communautaires) and English Canada's community health centres, which are described below. In addition, Saskatchewan's experience with wide scale integration of services is also described.

As Thompson notes in a comprehensive survey of experience in Canada, US and Great Britain with integrated human services (Thompson, 2007), integration is a process and not a single model. There is no one approach that can be applied in all situations. Rather it is a goal that must be tailored to each individual situation.

Selected key informant comments about integrated services

One key informant noted this seamless approach is particularly helpful for the complex client base that represents the population most negatively impacted by health determinants:

"Many of the people who are seeking services are people who have problems and issues of many sorts and they are not capable of running around town to different services. Some of these people have low educational levels, and they may have drug/alcohol issues, or they may be a single parent encumbered by small children. So it may be difficult for them to access services for a whole bunch of reasons."

Give that process, however, there are some common elements that contribute to the success of service integration and some predictable pitfalls that can undermine their effectiveness.

7.1 Critical success factors and barriers to integrated human services

Thompson notes that barriers to integration are mentioned more often than success factors and the integration of services is not easy to do. The following success factors and barriers have been identified (Thompson, 2007):

1. Factors that contribute to an environment in which the development of successful integrated services is more likely to occur include:

- **Strong leadership** - Leaders who are champions of integration, and are passionate about and committed to this approach make a real difference. Leaders are needed in all disciplines and at both the senior management level and at the community level.
- **Governance structures** - Clearly articulated and understood governance and accountability mechanisms are critical to the success of any partnership, and they must be agreed upon at the senior level from the outset of the relationship.
- **Accountability measures** - Accountability mechanisms that are clearly articulated help measure progress and determine whether goals are being met.
- **Management skills/experienced managers** - Program managers and members of the local human service community who have many years of experience and know their communities well are important for success.
- **A clearly defined, shared mission** - A clear mission statement that is developed by representatives of the partner organizations and community members help create a sense of connection among diverse individuals and organizations.
- **A willingness to take chances, experiment and change** - Service integration means new approaches and new ways of doing things. There needs to be a willingness to take risks, and the flexibility to implement innovative strategies and to change direction if an approach is unsuccessful. Thompson notes this attitude is quite the opposite of the risk-averse culture that is typical of many government agencies.
- **A community focus** - Communities have to be actively involved in providing the resources necessary for integration, which means that communities also need to be involved in planning and implementing integrated projects (Ragan, 2003). A strong local coalition can be a powerful force for change
- **Client/citizen-centred services** - A client/citizen-centred approach to integration has two dimensions:
 - **Client consultation** – consumers and other stakeholders should be consulted on a regular basis to find out what their needs and expectations are. Community members and stakeholders need a certain level of comfort and trust in order to participate in consultations, so consultations may be preceded by opportunities to participate in non-threatening community

projects and events. At a case management level, focusing on the client means involving clients when goals for them are set and when their case is discussed by cross program teams.

- **A strength-based or asset-based approach** – Assessment and case management processes are based on an individual's or family's strengths rather than their deficits, and families are supported in recognizing and building on their strengths.

2. Factors that are barriers to an environment in which the development of successful integrated services is more likely to occur include:

- **Confidentiality of Information** -- Real or perceived issues around sharing of client information is one of the barriers most frequently raised. Managers who have addressed this issue, however, say that it may be something of a diversion. Staff who claim that the rules of their programs prevent information sharing, may be using confidentiality as an excuse for resisting efforts to integrate services. Ragan (2003) notes that information sharing is particularly problematic when different levels of government are responsible for program administration. In this situation, substantial time and effort may be needed to reach agreement among the various levels of government and to set up security systems that ensure only staff with the necessary clearances have access to information.
- **Resistance to Change and Change Fatigue** – Individuals, professionals and agencies may be risk adverse. All change requires a certain amount of risk; integrated service delivery requires a transformation of the way ministries, agencies, professionals and individuals traditionally do business. Integration means each player no longer has complete control over a process, service channel, etc., and that control is now shared between partners. There may be turf protection and an unwillingness to share control. Even when individuals and organizations are initially supportive of change, significant ongoing change can induce change fatigue. This is particularly true when there are decreases in budget or staff. Sometimes, people simply do not have the resources, time and emotional energy to invest in further change when the outcome is uncertain. (New Zealand State Services Commission, 2003; Rutman et al., 1998)
- **Differences in Organizational Culture** – Different organizations, and particularly different government departments, have different cultures and different ways of doing things. These cultures may have developed over decades, may be deeply entrenched, and may affect virtually all aspects of operations. Organizational culture influences matters such as organizational goals, the degree of client focus, the language used to describe functions and services, approaches to case work, procedures for communicating within the organization and with external groups, and processes and procedures used for planning. Overcoming these differences in organizational culture can be challenging. Practitioners first need to understand each others' perspective and then to find common ground so work can proceed. Some experts say that the easiest way to do this is to set aside the goals and mandates of existing agencies, agree on a common direction and

purpose at the beginning of an integration initiative, and establish common goals and common assumptions that will guide future work.

- **Resources Issues** – Several issues around resources can present barriers to integration.
 - **Differences in partner capacity and resources** – Larger partners with more money may feel they have the right to control the agenda. A true collaboration requires that larger partners subordinate their goals to those of the partnership (Ragan, 2003).
 - **Agreeing on the contribution from each partner** – There may be differences of opinion about the amount that each partner should contribute.
 - **Difficulty obtaining funding** – There may be problems securing funding horizontally in a silo system. Government ministries may be reluctant to contribute funds to projects if they can not see tangible benefits that link directly to their ministry.
 - **No new funding** – Sometimes governments require that an integration initiative be implemented through re-alignment of existing funding. New funding is not provided. This may force creative solutions such as breaking a development strategy down into smaller more achievable segments, where results can be demonstrated each year.

But in spite of these challenges, there are good working models in Canada of integrated health and/or human services. Perhaps the best developed and longest duration models are the CLSCs in Quebec.

7.2 Quebec's CLSCs

Over the last three decades, particularly in Quebec, some of the major efforts to improve the health of local populations have come through the use of community health centres that integrate primary and preventive health services with social services. In Quebec these are called CLSCs (centre local de services communautaires). These are community clinics which are run and maintained by the provincial government. The network offers a wide variety of services including primary health care, preventive health services, psychological counseling, supportive services such as housing resources and subsidies, and community development. The CLSC's mission is to use a global, multidisciplinary and community approach to improve the state of health and well-being of individuals in the community. Furthermore, one of its goals is to make individuals and those close to them more responsible for taking charge of their health and well-being and health services. There are 147 CLSCs spread throughout the province.

In recent years, the CLSCs are no longer independent organizations but have been merged with CSSS (Centre de santé et de services sociaux) which are the local overarching health and social services organizations that also oversee all of the health related and social services-related services in a community, including nursing homes and hospitals. In Montreal and in the Outaouais, the health services are provided by the (CSSS) which are like CLSCs but with the addition of the integration of acute care

hospitals, longterm care and rehabilitation services into the model. All services can be first accessed by a single call in the Montreal region to 8-1-1 and this will direct the individual to the right resource.

The Montreal CSSS website (www.santemontreal.qc.ca) notes CSSSs were created to meet the challenges of the population approach, which involves more proactive health care management, and helps to maintain and improve citizens' health. They have been given the responsibility to define the clinical and organizational project.

According to the Montreal CSSS, in order to create a true local network focused on population responsibility, CSSSs must rally network and community actors to progress through a series of steps that can be defined in the following manner:

- Establish a picture of the health of the territory's population, taking into account the sociodemographic profile of clientele and of the population, the health profile, i.e. determinants of health and sociodemographic and environmental trends, and the service use profile.
- Define the priorities that reflect the local vision of needs. In order to identify expected results clearly, it is necessary to secure the participation of health-network actors and of other resources within the region. It is of foremost importance for the population to be a stakeholder in the project.
- Identify effective interventions, both at the clinical and organizational levels. They must have proven effectiveness in improving the population's health and well-being.

7.3 Community health centres in English Canada

Community health centres in English Canada are non-profit, community-governed organizations that integrate primary health care, health promotion and community development services, using multi-disciplinary teams of health providers. These teams often include physicians, nurse practitioners, dietitians, health promoters, counsellors and others who are paid by salary, rather than through a fee-for-service system. Community Health Centres are sponsored and managed by incorporated non-profit community boards made up of members of the community and others who provide health and social services.

Services are designed to meet the specific needs of a defined community. In addition, CHCs provide a variety of health promotion and illness prevention services which focus on addressing and raising awareness of the broader determinants of health such as employment, education, environment, isolation and poverty. CHCs have been in existence in Canada since the 1920s; today, there are more than 300 CHCs across Canada, including some 55 CHCs in Ontario.

The approach to community health encompasses the broad factors that determine health such as education, employment, income, social support, environment and housing. Some of the typical services found in CHCs are the following:

- **Primary Care-** Health Assessment, Illness prevention; Interventions for acute and episodic illness or injury; Primary reproductive care; Early detection of initial and ongoing treatment of chronic illness; Education and support for self-care;

Support for care in hospital, home and long-term care facilities; Arrangements for 24-hour/7-day a week response; Service co-ordination and referral; active recall and maintenance of a comprehensive medical record (often electronic) for each client in the centre; Primary mental health care including psycho-social counseling; Coordination and access to rehabilitation; Support for people with a terminal illness.

- **Health Promotion and Community Capacity Building** - Smoking cessation; Asthma health promotion; Nutrition workshops; Diabetes education; Housing security and homelessness; Food security; Access to employment; Supports to immigrants and refugees such as ESL preparation; Parenting support groups; Farm safety; Breast feeding support;; Childbirth preparation; Seniors drop-in and senior recreations; Stress or Anger management; Self-esteem counselling; Violence prevention; Community justice conflict resolution; Community kitchen, gardens; Multilingual programming on a variety of topics; Youth programs; Women's support group; and School snack programs (Association of Community Health Centres, 2009).

A recent study in Ontario found that care for people with chronic illness, particularly diabetes, was more effective through CHC's than through traditional doctor's offices, largely because of the network of multidisciplinary teams. The Ontario Health Quality Council's 2008 QMonitor Report found CHCs perform significantly better than individual physicians and other health organizations in managing chronic illnesses, particularly diabetes, but they also do so with population groups that typically face greater barriers to health and health care due to poverty, inadequate housing, language, geographic isolation and other factors: "... the focus isn't limited to health care. Its work is based on the understanding that a range of factors, including housing, employment, social connections, income and biology and gender and race, which we call the determinants of health, all affect whether people are healthy" (OHQC Annual Report, 2008).

CHC's are very promising models but in their 30 years of existence in Canada, they have not experienced widespread support. This is a function primarily of some of the barriers noted earlier. In addition, funding models, particularly having physicians on salary, have been opposed by physician groups, as has been the sharing of control between various health professions, rather than the traditional hierarchy. New generations of physicians are showing less resistance to the community health model and to salaried positions, and many provincial governments are encouraging the creation of CHCs and/or family practice networks (a sort of virtual CHC) as part of primary care reform.

7.4 Human services integration in Saskatchewan

Other than CLSCs and Community Health Centres, there appears to have been surprisingly few systematic attempts to integrate other human services in Canada. Where there are models, they are either partial (e.g. health and social services are integrated in Quebec, Manitoba has a multi-ministry focus on children) or primarily local (e.g. some multi-service centres in Ontario). Only one province appears to have made a systematic attempt to more closely integrate a broad cross-section of human services at a provincial and regional level – Saskatchewan.

Saskatchewan has had an integrated approach to the delivery of human services since 1989 and was one of the first jurisdictions to adopt this approach. Service integration is coordinated through two organizational structures: the Human Service Integration Forum (HSIF) and the ten Regional Intersectoral Committees (RICs).

- The Human Services Integration Forum is comprised of Associate/Assistant Deputy Ministers of provincial government departments that provide human services including the departments of Education; Justice and Attorney General; Health; Social Services; First Nations and Métis Relations; Tourism, Parks, Culture, and Sport; and Corrections, Public Safety and Policing. The Human Services Integration Forum provides coordination of human services initiatives at the senior government level. An Executive Director supports the Human Services Integration Forum and the Regional Intersectoral Committees and coordinates strategic planning for service integration in Saskatchewan.
- Each of the ten RICs covers a specific area of the province. Each RIC has unique membership including representatives from provincial and federal government departments, schools, police, First Nations and Métis organizations, and other local human service organizations including community-based organizations. The RICs are responsible for coordinating human services at a regional level and for building community capacity. Each RIC is supported by a coordinator who is funded by the provincial government.²⁵

Recently, there has been an emphasis on renewing, revitalizing and re-energizing integrated services in Saskatchewan. This renewal of human service integration is the beginning of the second generation of integration in this province. In contrast, most integration initiatives underway in other jurisdictions are at the first generation stage

One example of services integration is in Regina where a community services village is centred at a foodbank bringing together 20 agencies who serve people who experience poverty. It required significant infrastructure cost to have a facility with that much space. But it is very convenient for clients and much easier for agencies to work together

7.5 Healthy Child Manitoba

In 1999, the Manitoba government committed to making early childhood development a government-wide priority. The following year, the government created Healthy Child Manitoba (HCM) and established the Healthy Child Committee of Cabinet, Canada's first and only long-standing cross-ministry cabinet committee dedicated to children and youth. The cabinet committee features the ministers of eight ministries (Healthy Living; Health; Aboriginal and Northern Affairs; Justice; Culture, Heritage and Tourism; Labour and Immigration; Education, Citizenship and Youth; Family Services and Housing.) These eight government partners share responsibility for developing, coordinating and implementing Manitoba's child-centred public policy, sharing a common goal to give all Manitoba children the best possible outcomes.

²⁵ Based largely on Thompson, 2007

The cabinet committee is supported by a deputy ministers committee as well as the Healthy Child Manitoba Office, which not only does policy development, community development and program evaluation, but acts as staff and secretariat to the two government committees.

While the unique cabinet committee sustains the political commitment and vision, the program also relies on strong community leadership and engagement. Across the province, 26 Parent-Child Centred Coalitions collectively decide what services and supports will best meet the needs of families in that specific area. This community development-centred approach brings together parents, school divisions, early childhood educators, health professionals and other community organizations through regional and community coalitions to support positive parenting, improve children's nutrition and physical health, promote literacy and learning, and build community capacity.

The objectives of HCM are to:

- research, develop, fund and evaluate innovative initiatives and long-term strategies to improve outcomes for Manitoba's children;
- coordinate and integrate policy, programs and services across government for children, youth and families using early intervention and population health models;
- increase the involvement of families, neighbourhoods and communities in prevention and early childhood development services (ECD) through community development; and
- facilitate child-centred public policy development, knowledge exchange and investment across departments and sectors through evaluation and research on key determinants and outcomes of children's well-being.

According to a positive summary in a 2006 article (Health Council of Canada, 2006), the result has been a strong web of public services that support children and families, including:

- prenatal benefit to help low-income women buy healthy food during pregnancy;
- a Stop FAS (fetal alcohol syndrome) program that matches mentors with women who are at risk of having a baby affected by alcohol;
- a universal screening program that reaches 90 per cent of newborns and their parents and offers family supports, such as home visits from the Family First program and links to local parenting programs;
- the Triple P Positive Parenting Program, internationally recognized for its capacity to build parenting skills and reduce behavioural issues; and
- early childhood development programming, such as a popular program called Alphabet Soup, which combines healthy eating with parent and child reading and language activities, building family literacy skills while helping parents learn about affordable nutrition. Alphabet soup uses local parents as volunteers and facilitators as part of community capacity building.

Other HCM activities in recent years include:

- improving primary health care services for teens through the expansion of teen clinics in the province.
- working collaboratively with partner departments on developing a FASD strategy.
- enhancing relationships with federal departments at the regional level, including Public Health Agency of Canada (PHAC) and First Nations Inuit Health Branch (FNIHB); and
- advancing the Healthy Child Manitoba Provincial Research and Evaluation Strategy. Evaluation of the project includes working with all 38 school divisions in the province to assess children's school readiness in kindergarten, examining the emotional, social and developmental maturity and their physical health during each child's kindergarten year. Other long-term evaluation strategies are being developed such using the National Longitudinal Survey of Children and Youth (NLSCY) and the development of a Manitoba- specific longitudinal study modeled after the NLSCY.

While the results of this long-term, integrated commitment are still in their infancy, it appears the political commitment is being maintained, making the Healthy Child Manitoba program one to watch in Canada for its impact on the health status of Manitoba's children.²⁶

7.6 A vision for integrated health and human development services

While there are a number of potentially useful models of health and/or human services integration, there seems to be a lack of vision of what such a system might be in the future. One attempt to develop such a vision came from the work of a team that was creating the design of a new community – Seaton – that was being planned by the Ontario government in the 1990's. In the end the community was not built, but as part of its comprehensive design (which placed third in the design competition), the CEED²⁷ Consortium's Community group developed a comprehensive human development strategy.²⁸

The strategy was based on three key principles, which were in order of priority:

- build community: build a strong, supportive, tolerant community committed to the welfare of its members - present and future - and the protection and enhancement of its environment;

²⁶ Sources: Sale (2003), Government of Manitoba (2007) and Healthy Child Manitoba Government website, www.gov.mb.ca/healthychild

²⁷ Community, Environment, Economy, Design

²⁸ Human wellbeing/development was just one of seven elements considered in the CEED Consortium's design for Seaton; the others were governance, ecosystem health, economic vitality, sustainable development, environmental quality and social equity.

- promote wellbeing and prevent problems: emphasize the promotion of wellbeing, the prevention of problems and the mobilisation of the self-help and mutual aid and support capacity of the community;
- meet needs and provide services: provide a comprehensive range of human services in an integrated system that is developed from the household level on up as an integral part of the community and the Pickering and Durham communities of which Seaton is a part.

The strategy had two main thrusts, which were complementary:

- emphasizing the creation of a strong community culture, the promotion of wellbeing and the prevention of problems ahead of the provision of services; and,
- building from the household level on up.

The key elements of the promotion/prevention component of the overall human, social and cultural strategy were:

1. Meet basic needs for all
2. Raise healthy children
3. Make work a source of wellbeing
4. Ensure healthy aging
5. Stimulate creativity and innovation
6. Create a sense of community
7. Ensure security
8. Enable people to become empowered
9. Provide promotive and preventive human services

The concept of building from the household level up applied not only to the human services system, but was in fact applied to the overall design of the whole community. It was recognised that in designing human services at the household, block and neighbourhood level, attention would have to be paid to the human service needs of individuals and the need for spaces and facilities to meet those needs. As a matter both of efficiency and of creating a greater sense of community, multi-use facilities managed by the block, the neighbourhood and the village were proposed. An example of the design implications is shown in Table 1, which explores what facilities might be needed at each level for two aspects of human development – learning and community services. A detailed description of health services based on this model can be found in Hancock, 1999.

Table 1: Some implications for selected human services by design levels, CEED proposal for Seaton design competition, 1994

<u>Design level</u>	<u>Learning Centre</u>	<u>Community Services Centre</u>
Household	<ul style="list-style-type: none"> • Interactive video terminal linked to the Seaton Electronic Learning Network and Community Information and Resource Centre 	<ul style="list-style-type: none"> • On-line access to the neighbourhood, village and town CSCs for advice and support. • On-line access to the Self-Help Clearing House and its self-help and self-care software. • Hard-wired house alarms (fire/smoke, seniors help, burglar)
Block	<ul style="list-style-type: none"> • On -line learning and resource rooms in large population blocks (i.e. multi-units). • Common spaces for play, recreation, crafts and other uses. 	<ul style="list-style-type: none"> • Community service rooms in large blocks for visiting human service workers.
Neighbourhood	<ul style="list-style-type: none"> • Elementary community school as centre for lifelong learning, with community recreational and cultural facilities, including community information and resource centre. 	<ul style="list-style-type: none"> • Housing for people with special needs
Village	<ul style="list-style-type: none"> • Community high school with community facilities for lifelong learning and recreation, including craft and hobby spaces, pool, gym, art and cultural spaces, library etc 	
Town	<ul style="list-style-type: none"> • Eco-Community College, home base for Seaton Electronic Learning Network, main cultural facilities including performance space, museum/gallery etc 	

8. Towards a national approach to supporting local action for population health and human development.

While there is undoubtedly a role for the federal governments in supporting the new community governance processes and structures needed to develop personal and community resilience and to build (on) community and individual capacity, it is important to recognize the vital role that must also be played by provincial governments. There are two important reasons for this: First, because municipal governments are established by provincial governments, and second because as Torjman (2007) notes:

“Many of the substantive areas with which this [communities] agenda is concerned – decent affordable housing, literacy and training and employment [and, one might add, education and health services] fall primarily within provincial domain.”

And of course, municipal governments also play a key role in areas that affect health and human development such as land use planning, transportation, waste management, parks and recreation, social services, social housing and other areas.

In a chapter entitled “Creating an enabling environment” Torjman (2007) examines the emerging role of federal and provincial governments and other (philanthropic) funders in strengthening community governance and enabling and supporting communities in developing personal and community resilience, beyond their role in investing directly in services, programs and facilities in communities.

She describes the new role as that of “enablers of complex community processes” and suggests that this requires these funders to enable “knowing, doing and reviewing – building the evidence base, developing collaborative relationships and reviewing progress” (p 244). She provides a number of ideas for how this might be done:

- Enabling knowing involves sharing with the community information held by governments (e.g. the Community Accounts Project begun in Newfoundland and Labrador, and now being copied in other provinces); supporting community-based and community-driven research and the collection and analysis of information; supporting links between communities and researchers (e.g. the Community-University Research Alliances program of SSHRC); and sharing knowledge and experience between communities. (Here it is useful to recall John McKnight’s oft-repeated adage that “institutions learn from studies, but communities learn from stories”.)
- Enabling doing by supporting community governance processes that work collaboratively to address complex problems; investing “patient capital” in this process over the long term; participating “as active partners” and sharing information on good practice from across the country; and by modelling coordination and collaboration in their own work by working horizontally and adopting a ‘whole of government’ approach.
- Enabling reviewing by supporting learning within and between communities, including reflective practice, behavioural assistance and skills development.

It is vitally important to recognize that in seeking to build (on) community capacity to improve health and human development, there is no single model that can be applied to all communities. Every community is different in terms of its history, the problems it faces, the resources it can bring to bear and the relationships that already exist within the community, and between the community and other, higher levels of government.

Selected key informant comments about single models

"I don't think you can take a model from one place and transpose it to another area. . . . I would definitely say that one size definitely does not fit all."

"I think that one of the things that we now recognize is that rather than talking about models, we talk more about principles."

Nonetheless, based on the research we have conducted for this report, the views of the key informants, and my own experience over the past 25 years of work in healthy cities and communities, the following observations can be made.

1. Many of the determinants of health have their effects at the community level, in the settings – homes, schools, workplaces, neighbourhoods – where people live, learn, work and play.
2. Communities – even the most challenged and disadvantaged communities such as the Cree community of Ouje-Bougomou described earlier in this report – have significant and sometimes astonishing strengths, capacities and assets that can be used by the community to address their problems and to enhance their health, wellbeing and level of human development.
3. Provincial and federal governments, philanthropic organizations and the private sector would be wise to recognize the strengths inherent in communities, and to build upon and enhance community capacity by adopting the strategy of investing in asset-based community development.
4. Such a strategy requires, among other things:
 - a. Recognizing the vital role played by municipal governments in creating the conditions for health and human development, making them key partners, and strengthening their powers (including their taxing powers).
 - b. Adopting a holistic 'whole-of-government' approach to issues of population health and human development at all levels of government, from the federal to the local.
 - c. Encouraging and supporting the creation of community governance processes and structures that enable the many stakeholders in the community – public, non-profit, private and community sectors, as well as individual citizens – to identify and define local community issues and solutions and to develop long-term, asset-based strategies to address them.
5. This in turn requires a commitment by governments and philanthropic organizations to long-term funding of this community governance infrastructure. Specifically this means a commitment to provide less narrowly targeted and short-term funding and more long-term general funding that communities can use in

ways that they see fit to address the challenges they have defined and to build the community capacity they require.

6. At both the national and provincial levels, there is a need to establish (or where they already exist, to greatly strengthen) national and/or provincial organizations that can support the creation of healthy schools, healthy workplaces and healthy communities. These organizations would facilitate and support the creation of community governance infrastructures, undertake research, share knowledge and experience, develop tools and 'train that trainers'.
7. Any national effort to improve population health and human development health through community-based action to create healthier communities needs to include a national effort to develop new measures of progress, so that our progress towards these broad societal goals can be tracked. These new measures need to be applicable at all levels from the national to the local, and their development needs to be done in partnership with communities, as part of the development of the community's capacity to understand itself and its situation, a necessary prerequisite for taking action
8. As one part of building (on) community capacity, governments should develop more integrated systems of human development services. Particularly in disadvantaged communities, these services should be co-located close to the people who use or need them; they should be easy to use and navigate ('one-stop shopping') and where possible they should be housed in a single facility that maximizes the use of the shared space throughout the day.

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Appendix 1: Healthy cities and communities - then²⁹

"The greatest contribution to the health of the nation over the past 150 years was made not by doctors or hospitals but by local government."

--Dr. Jessie Parfitt, in *The Health of a City: Oxford, 1770-1974*

History shows us why it makes sense to address population health at the community level. As Dr. Thomas McKeown noted in his famous writings in the 1970s (McKeown, 1979), the great gains of life expectancy and human health over the last 200 years came from clean water, improved sanitation and sewage control, better nutrition and increased standards of living – all occurring at the community level, and none of them the result of improved health care per se.

Indeed, attempts to improve the health of cities and their citizens date back at least to the time of Hippocrates, the Greek "father of medicine" who was the first to observe that disease was often related to factors like diet, physical fitness, and living environment (Hippocrates, 400 BC). Renaissance Italy, in its fight against successive waves of plague, recognized the link between ill health and place. They set up city health boards, called Special Magistracies, that combined legislative, judicial, and executive powers in the city or region. These boards exercised authority over all matters pertaining to health of the population, including include everything from the food system to public works like sewage, water and refuse, the provision of services and the regulation of economic activities like hostleries and prostitution.(Cipolla, 1976).

In the 19th Century, European, British and North American cities witnessed serious health problems spurred by the industrial revolution, particularly overcrowding, malnutrition, poor or unsafe housing, and inadequate provision for water, sanitation, waste removal, and pollution control. This led to the emergence of the sanitary ideal and the public health movement, initially in Victorian England and then throughout the industrialising countries of Europe and North America. Cities became a prime focus for the work of public health, from the establishment of the Health in Towns Commission in Britain in 1843, through the description by Sir Benjamin Ward Richardson in 1875 of "Hygeia," as a comprehensive and detailed vision of a "City of health" in an idealized future.

In Canada, the Commission on Conservation, created by the Canadian government in 1909, included a Public Health Committee which addressed the issue of town planning because it noted it encompassed both the physical (conservation of natural resources) and the vital (protection of people's health.) Their work led to a national conference in 1913, and they secured the services of Thomas Adams, a renowned advocate and practitioner of town planning from the UK. As the commission's town planning adviser, from 1914 to 1919, he revised the commission's model town planning bill and had a hand in preparing town planning bills in most of the provinces, prepared a pioneer document on rural planning and development, consulted with nearly forty local councils, wrote for a quarterly bulletin called Conservation of Life put out by the Commission, helped to organize the Civic Improvement League, and in 1919 was elected as the first president of the Town Planning Institute of Canada. At the same time, in Toronto, and inspired by similar ideals, Dr Charles Hastings, the Medical Officer of Health from 1910 – 1929, led

²⁹ Based on Hancock, 1990

the city to becoming the “Healthiest of Large Cities” in the world (MacLean's Magazine, July 1919) and the Department of Public Health to become internationally recognized.

In the United States, a similar focus on healthy cities was taking shape. The Inter-Chamber Health Conservation Contest was established in 1929 by the U.S. Chamber of Commerce in partnership with the American Public Health Association, the National Association of Life Underwriters, and the U.S. Public Health Service. The contest ranked cities on the basis of sanitary measures, disease prevention, health promotion, financial support for health work, and death rates. The purpose was two-fold: to acquaint citizens, particularly businessmen, with the local health agency and the community's local health problems “with the aim to bring about improvements and economic gain;” and second, to reduce preventable illness and untimely death (Gold, 1930). For six consecutive years between 1929 and 1935, the city of Milwaukee, Wisconsin - which in Maclean's Magazine had been ranked second to Toronto - came in first or second in the contest for the large city category (500,000+ population).

Thus we can see that the health of towns and cities was a matter of international and national concern for the best part of a century. What this history lesson teaches us, as Jessie Parfitt noted, is indeed that “The greatest contribution to the health of the nation over the past 150 years was made not by doctors or hospitals but by local government.”

Sadly, with the advent of modern medicine in the 1930s, when the first antibiotics became available, and the explosion of effective medical and surgical care that followed the Second World War, the importance of public health was diminished, and the hard won lessons, if not lost, became neglected. It was not until the Lalonde Report in 1974 stated that there were four ‘health fields’ – of which health care was but one - and that future improvements in the health of Canadians would largely result from improvements in lifestyle and environments – that the balance began to shift again, and with it we saw the re-emergence of a modern-day healthy cities and communities movement.

Appendix 2: Healthy cities and communities - now

The world-wide healthy cities and communities movement had its modern origins in Canada, at a 1984 conference held to celebrate the centennial of the Local Board of Health and the sesquicentennial of the City of Toronto. The conference, which was entitled “Beyond Health Care” (Hancock, 1985) was the first conference to explore the concept of ‘healthy public policy’ and was linked to a one-day workshop – “Healthy Toronto 2000.” The idea was to envision a future city in the context of the Department of Public Health’s goal of making Toronto once again “the healthiest city in North America.” The keynote presentation was by Len Duhl, a pioneer of the healthy community concept in the 1960s and a professor of public health at Berkeley, CA.

The idea of a ‘healthy city’ was picked up by attendee Ilona Kickbusch, then Health Promotion Officer for WHO in Europe. She saw in the healthy city concept the potential to take health promotion then under development at WHO Europe onto the streets of the cities of Europe, to take global concepts and apply them locally and concretely.

In January 1986, a small group of health promoters, convened by Kickbusch, gathered at the WHO Regional Office for Europe in Copenhagen to plan a WHO Europe healthy cities project. The WHO planning group anticipated that their project might attract the interest of six to eight cities. But the WHO Europe Healthy Cities Project began with a Healthy Cities symposium in Lisbon in April 1986, attended by fifty-six participants from twenty-one cities and seventeen countries. Eleven cities were selected for the WHO project in 1986, but the popularity of the project translated to the selection of another fourteen cities in 1988, growing to thirty-five cities by 1991.

Today, there are Healthy Cities networks established in all six WHO regions, including more than 1200 cities and towns from over 30 countries in the WHO European Region; these cities are linked through national, regional, metropolitan and thematic networks. In the Pan-American Region it is known as ‘healthy municipalities’ and involves hundreds of municipalities in many countries, particularly Mexico and Brasil. There is also a very strong Healthy Cities network in the South East Asia Region, a ‘healthy villages’ network in the Eastern Mediterranean Region, a small healthy cities network in the African Region and a ‘healthy islands’ network in the Western Pacific Region.

The WHO Europe Healthy Cities program engages local governments in health development through a process of political commitment, institutional change, capacity building, partnership-based planning and innovative projects. It promotes comprehensive and systematic policy and planning with a special emphasis on health inequalities and urban poverty, the needs of vulnerable groups, participatory governance and the social, economic and environmental determinants of health. It also strives to include health considerations in economic, regeneration and urban development efforts.

The WHO Europe Healthy Cities program has just finished its fourth phase (2003–2008). Cities currently involved in the Phase IV Network worked on three core themes: healthy ageing, healthy urban planning and health impact assessment. In addition, all participating cities focused on the topic of physical activity/active living. Now Phase V has begun (2009–2013).

The overarching theme for Phase V is health and health equity in all local policies. “Health in all policies” is based on a recognition that population health is not merely a product of health sector activities but largely determined by policies and actions beyond the health sector. As part of the launch of Phase V European mayors and civic leaders who are members of the healthy cities network have pledged to promote health, prevent disease and disability, and take systematic action on inequality at the civic level. City leaders will be advocates and custodians of their citizens’ health.³⁰

³⁰ This section on the global movement is based largely on information found at www.euro.who.int/healthy-cities

Appendix 3: Key informants

- Paul Born, President, Coach and Strategic Consultant, Tamarack - An Institute for Community Engagement, Waterloo, Ontario
- Joey Edwardh, Executive Director, Community Development Halton, Burlington Ontario
- Ron Labonté, Canada Research Chair in Globalization and Health Equity, Institute of Population Health, University of Ottawa
- Louise Potvin, CHSRF Chair in Community Approaches to Inequalities in Healthcare, Department of Social and Preventive Medicine, Université de Montréal
- Lorraine Thompson, Lorraine Thompson Information Services Limited, Regina, Saskatchewan
- Sherri Torjman, Vice president, Caledon Institute of Social Policy, Ottawa, Ontario

LIST OF WITNESSES

39 th Parliament 1 st Session		
ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE
World Health Organization Commission on the Social Determinants of Health	The Honourable Monique Bégin, P.C., Commissioner	22-02-2007
Institute of Population Health	Ronald Labonté, Canada Research Chair in Globalization and Health Equity	28-02-2007
Provincial Health Services Authority, B.C.	Dr. John Millar, Executive Director, Population Health Surveillance and Disease Control	28-02-2007
School of Health Policy and Management - York University	Dennis Raphael, Professor	28-02-2007
Public Health Agency of Canada	Jim Ball, Director, Development and Partnerships Division, Strategic Policy Directorate, Strategic Policy, Communications and Corporate Services Branch Maura Ricketts, Acting Director General, Office of the Public Health Practice, Public Health Practice and Regional Operations Branch Dr. Syvlie Stachenko, Deputy Chief Public Officer, Disease Prevention	21-03-2007
Kunin-Lunenfield Applied Research Centre	Sholom Glouberman, Associate Scientist	21-03-2007
Statistics Canada	Michael Wolfson, Assistant Chief Statistician, Analysis and Development	21-03-2007
Institute of Population and Public Health	Dr. John Frank, Scientific Director of the Canadian Institutes of Health Research	28-03-2007
Global Health and Social Policy	Dr. Jody Heymann, Canada Research Chair in Global Health and Social Policy	28-03-2007
McGill University	Dr. John Lynch, Canada Research Chair in Population Health	28-03-2007

Public Health Agency of Canada	Jim Ball, Director, Development and Partnership Division, Strategic Policy Directorate	25-04-2007
Indian and Northern Affairs Canada	Marc Brooks, Director General, Community Development Branch, Socio-economic Policy and Regional Operations sector	25-04-2007
Centre for Aboriginal Health Research, University of Manitoba	John O'Neil, Professor and Director	25-04-2007
Health Canada	Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch	25-04-2007
Institute of Aboriginal People's Health (IAPH) for the Canadian Institutes of Health Research (CIHR)	Dr Jeff Reading, Scientific Director	25-04-2007
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Canadian Association on Gerontology	Mark Rosenberg, Professor Queen's University	16-05-2007

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Canadian Institutes of Health Research	Dr. Michael Kramer, Scientific Director, Institute of Human Development, Child and Youth Health	30-05-2007
Council of Early Child Development	Stuart Shankar, Professor, President	30-05-2007
Manitoba Métis Foundation	Dr. Judy Bartlett, Director of Health and Wellness Department and Associate Professor, Department of Community Health Science, Faculty of Medicine, University of Manitoba	31-05-2007
Métis National Council	David Chartrand, Minister of Health Marc LeClair, National Advisor to the Minister of Health Rosemarie McPherson, National Spokesperson for Women of the Métis Nation	31-05-2007
BC Ministry of Health	Dr. Evan Adams Aboriginal Health Physician Advisor, Office of the Provincial Health Officer	01-06-2007
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Assembly of First Nations	Valerie Gideon, Director of Health and Social Development	01-06-2007
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Toronto University	Chandrakant P. Shah, professeur émérite	01-06-2007
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39th Parliament 2nd Session		
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B.C. Interior Health Authority	Lex Baas, Director of Population Health	12-12-2007
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Ontario Ministry of Health Promotion	Pegeen Walsh, Director Chronic Disease Prevention	06-02-2008
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University of Ottawa Heart Institute	Dr. Andrew Pipe, Medical Director, Prevention and Rehabilitation Centre	06-02-2008
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University of Manitoba	Noralou Roos, Professor, Faculty of Medicine	13-02-2008
Public Health Agency of Canada	Jim Ball, Director General, Strategic Initiatives and Innovations	27-02-2008
Treasury Board of Canada	Sally Thornton, Indian Affairs and Health	27-02-2008
Finance Canada	Yves Giroux, Acting Director, Social Policy	27-02-2008
McMaster University	Dr. Salim Yusuf, Professor, Department of Medicine	02-04-2008
McMaster University	Dr. Sonia Anand, Associate Professor, Department of Medicine	09-04-2008
Queen's University	Karen Hitchcock, Principal and Vice-Chancellor Kristan Aronson, Professor of Epidemiology	09-04-2008
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Provincial Health Services Authority, B.C.	Dr. John Millar, Executive Director, Population Health Surveillance and Disease Control	14-05-2008
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United Nations Association in Canada	Kathryn White, Executive Director	28-05-2008
The Society of Obstetricians and Gynecologists of Canada	Dr. André Lalonde, Executive Vice-President	28-05-2008
Canadian Pediatric Society	Marie Adèle Davis, Executive Director	28-05-2008
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40th Parliament 2nd Session

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Métis National Council	Barbara Van Haute, Director, Programs Development	25-03-2009
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Native Women's Association of Canada	Erin Wolski, Health Director	25-03-2009

Aboriginal Nurses Association of Canada	Rosella Kinoshameg, President	26-03-2009
Health Canada	Kathy Langlois, Director General, Community Programs Directorate, First Nations and Inuit Health Branch Catherine Lyons, Director General, First Nations and Inuit Health Branch Shelagh Jane Woods, Director General, Primary and Public Health, First Nations and Inuit Health Branch	26-03-2009
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Agriculture and Agri-Food Canada	Christine Burton, Director, Rural Policy and Strategic Development	27-03-2009
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Health Canada	Karen Dodds, Assistant Deputy Minister	27-03-2009

Newfoundland and Labrador Department of Finance	Alton Hollett, Assistant Deputy Minister, Economics and Statistics Branch	27-03-2009
Ontario Agency for Health Protection and Promotion	Dr. Vivek Goel, President and Chief Executive Officer	27-03-2009
Public Health Agency of Canada	Dr. Gregory Taylor, Director General, Office of the Public Health Practice	27-03-2009
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**Agir localement :
Promotion de la santé de la population**

**Rapport présenté
par Dr Trevor Hancock
consultant en promotion de la santé
Victoria (C.-B.)**

**au
Sous-comité sénatorial sur la santé de la population**

mars 2009

Table des matières

Sommaire

1. Introduction
2. Aperçu du développement humain sain
 - 2.1 Santé de la population et développement humain
 - 2.2. Le « droit » au développement humain
 - 2.3 Renforcement du capital communautaire – les cinq formes de capital
 - 2.4 Nouvelles mesures de progrès
 - 2.5 Renforcement de la résilience des gens et des communautés
3. Création de communautés plus saines, renforcement du développement humain
 - 3.1 Communautés saines au Canada
4. Mobilisation communautaire et renforcement des capacités
 - 4.1 Mobilisation communautaire
 - 4.2 Partenariats intersectoriels
 - 4.3 Engagement politique
 - 4.4 Politique publique saine
 - 4.5 Développement communautaire reposant sur les actifs
5. Nouveaux modèles de gouvernance communautaire pour la santé et le développement humain
 - 5.1 Le Tamarack Institute et les Collectivités dynamiques
 - 5.2 Conseils de planification sociale et Inclusive Cities Canada
 - 5.3 L'Accord de Vancouver
 - 5.4 Oujé-Bougoumou – Une communauté autochtone inspirante
 - 5.5 Gouvernance urbaine saine
 - 5.6 Création d'une infrastructure pour la gouvernance urbaine
6. Obstacles à la gouvernance communautaire et à l'action communautaire pour la santé et le développement humain
 - 6.1 Approche fragmentaire aux problèmes communautaires – nécessité d'une approche plus exhaustive
 - 6.2 Absence de vision nationale d'ensemble
 - 6.3 Ententes municipales dépassées
 - 6.4 Absence de structures communes pour la gouvernance communautaire
 - 6.5 Limites de financement

- 6.6 Absence de consensus sur le soutien pour plus de programmes universels
- 6.7 Limites imposées par les règlements sur les organismes charitables et sur les investissements sociaux
- 6.8 Épuisement du secteur bénévole
- 6.9 Difficultés à mettre en commun les cas de réussite au Canada
- 7. Services sociaux communautaires intégrés
 - 7.1 Services sociaux intégrés – facteurs de succès déterminants et obstacles
 - 7.2 Les CLSC du Québec
 - 7.3 Les Centres de santé communautaires du Canada anglais
 - 7.4 Intégration des services sociaux en Saskatchewan
 - 7.5 Enfants en santé Manitoba
 - 7.6 Une vision de services de développement humain et de santé intégrés
- 8. Vers une approche nationale axée sur le soutien de l'action communautaire au profit de la santé de la population et du développement humain

Références

Encadrés

- 1. Certaines propositions fondamentales pour la promotion de la santé de la population et le développement humain sain au niveau local
- 2. Développement humain– concepts de base et définition
- 3. La ville saine : définition et critères
- 4. Des fonds de contrepartie donnent un nouveau visage à Seattle
- 5. Calgary poursuit l'objectif du salaire-subsistance dans le cadre des Collectivités dynamiques
- 6. Le bâtiment Woodward réaménagé agrmente le DTES d'un espace innovateur à usage multiple
- 7. L'histoire d'Oujé-Bougoumou
- 8. *Our cities, our health, our future : Acting on social determinants for health equity in urban settings*

Figures

- 1. Capital communautaire et développement centré sur la personne
- 2. PIB et IPR, États-Unis, 1950 - 2004
- 3. Partenariats intersectoriels
 - 3a. Action interservices/interministérielle/interorganisationnelle
 - 3b. Action intersectorielle

3c. Intégration verticale

Tableaux

1. Certaines répercussions des services sociaux sélectionnés, selon le niveau de conception, proposition de CEED pour le concours relatif à la conception de Seaton, 1994

Annexes

Annexe 1 : Villes-santé/communautés-santé – hier

Annexe 2 : Villes-santé/communautés-santé – aujourd’hui

Annexe 3 : Intervenants clés

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Je remercie également mon employeur régulier, le ministère pour la Vie Saine et le Sport de la Colombie-Britannique, pour son appui dans la préparation de ce rapport. Cependant, ce sont mes points de vue que j'y exprime et ceux-ci ne représentent pas forcément ceux du Ministère ou du gouvernement de la Colombie-Britannique.

Sommaire

On ne peut parler de la santé des individus, la comprendre, ou prendre des mesures à son égard, si l'on ne reconnaît pas que les êtres humains sont des animaux sociaux qui ont évolué pour vivre dans des familles, des groupes sociaux et des communautés. La « communauté » est donc le creuset dans lequel agit un grand nombre des déterminants de la santé les plus importants comme les lieux où nous vivons, où nous apprenons, où nous travaillons, où nous nous divertissons – nos maisons, nos écoles, nos lieux de travail et nos quartiers.

En fait, le Sous-comité sénatorial sur la santé de la population a dégagé 12 principaux facteurs ou conditions – déterminants de la santé – qui interviennent en faveur ou au détriment de la santé des Canadiens. De ces 12 facteurs, il y en a bien 10 qui ont une influence au niveau communautaire.

Dans notre rapport, nous faisons valoir que puisqu'un si grand nombre de ces déterminants a des effets au niveau local, c'est à ce niveau qu'il faut intervenir. Que pouvons-nous donc faire pour aborder tous ces déterminants de la santé au niveau communautaire, ou du moins certains d'entre eux? Que fait-on actuellement dans les communautés canadiennes? Comment les gouvernements fédéral, provinciaux et territoriaux peuvent-ils soutenir ou promouvoir l'action communautaire pour la santé et le développement humain?

La notion fondamentale de promotion du développement humain sain sous-tend la promotion de la santé communautaire. La tâche de promouvoir un développement humain optimal – de sorte à nous permettre à tous de développer de façon optimale notre potentiel humain – est, ou devrait être, l'objectif premier de tous les ordres de gouvernement. On devrait consacrer la même attention et la même énergie au développement de la population d'un pays qu'au développement économique de ce pays. Nous commencerons donc par établir les fondements conceptuels du développement humain sain, en particulier la notion de création des cinq formes de capital, à savoir, le capital naturel, le capital économique, le capital social, le capital bâti, et le capital humain qui, ensemble, forment le « capital communautaire ». Ces concepts qui représentent ce que devrait être notre objectif sociétal doivent devenir les principaux indicateurs de nos progrès. Pour rendre cela possible, il faut de nouvelles mesures qui permettent de mieux saisir et intégrer ces diverses dimensions du bien-être sociétal, communautaire et personnel.

Trouver un équilibre approprié entre ces formes de capital souvent concurrentielles de sorte à mobiliser les citoyens de tous les secteurs de la communauté et, idéalement, maximiser simultanément toutes ces formes de capital, est au cœur de l'art de la gouvernance locale de la santé et du développement humain. Le processus de gouvernance permet de mobiliser l'ensemble de la communauté pour trouver le bon équilibre, c'est-à-dire « la somme des différentes manières utilisées par les individus, les institutions publiques et privées pour planifier et gérer les affaires communes de la cité » (ONU-Habitat, 2002). Parmi les principaux éléments de la gouvernance de la santé communautaire, quatre ont été définis il y a plus de 15 ans dans le cadre du projet des Villes-Santé du bureau régional de l'OMS pour l'Europe : il s'agit de la mobilisation

communautaire, de l'action intersectorielle, de l'engagement politique et de la politique publique saine.

Pour améliorer la gouvernance de la santé et du développement humain, il est nécessaire d'investir dans le renforcement de la résilience, « capacité de faire face à des problèmes difficiles et au changement constant, mais à en sortir grandi et renforcé » (Torjman, 2007), des gens et des communautés, et dans le processus et les structures nécessaires à la gouvernance communautaire.

Nous examinons dans notre rapport les nombreuses façons dont le Canada crée des communautés plus saines et renforce le développement communautaire et humain. Un point fondamental ressort de cet examen, à savoir qu'il n'existe pas de modèle universel pouvant ou devant être appliqué à toutes les communautés. Il nous faut un processus modèle qui appuie et habilite les communautés et leur permette de se mobiliser avec leurs citoyens et avec les divers organismes du secteur privé, organismes communautaires, organismes sans but lucratif et organismes publics, en vue d'élaborer une vision commune et originale adaptée aux interventions qui permettra de la réaliser.

Un second point fondamental apparenté qui émerge a trait au fait que cette approche doit être fondée sur les points forts et les actifs de la communauté, non sur ses faiblesses et ses dysfonctionnements. Au Canada, un nombre de plus en plus grand d'initiatives suit cette approche, par exemple :

- **Le mouvement des communautés saines** – Issu en partie de la Charte d'Ottawa présentée en 1986, le mouvement des communautés saines du Canada existe depuis plus de 20 ans. Bien que l'initiative fédérale ait disparu avec les compressions budgétaires de 1991-1992, Villes et Villages en Santé du Québec et la Coalition des communautés en santé de l'Ontario sont toujours des mouvements très actifs. L'initiative des communautés saines de la Colombie-Britannique a refait surface en 2005 grâce à un nouveau financement de la province. Ces trois initiatives provinciales ont adopté une approche élargie qui réunit les facteurs économiques, sociaux et environnementaux qui, tous, facilitent et soutiennent l'action communautaire menée au sein des communautés. L'initiative du Québec accorde une place particulièrement importante aux administrations municipales et au lien avec ces administrations, alors que celle de l'Ontario se concentre plus particulièrement sur les organismes et les réseaux communautaires; l'initiative de la Colombie-Britannique, forte de l'expérience de ses deux partenaires, fait les deux, puisqu'elle est située organisationnellement à l'Union of BC Municipalities et qu'elle met fortement l'accent sur le renforcement des capacités communautaires.
- **La mobilisation communautaire et le renforcement des capacités** – Cinq stratégies essentielles mettent à profit la capacité communautaire existante pour améliorer la santé de la population et favoriser le développement humain :
 - la **mobilisation communautaire** qui permet aux bénéficiaires passifs des services de devenir des participants et des chefs responsabilisés;
 - les **partenariats intersectoriels** qui franchissent les barrières entre les services ou entre les ministères gouvernementaux (l'ensemble du

gouvernement), dans de multiples secteurs, notamment par la création de vastes coalitions, ou par l'intégration verticale en établissant des liens entre les gouvernements fédéral, provinciaux et locaux;

- **l'engagement politique** qui dure idéalement au-delà d'un seul mandat et qui encourage la mobilisation communautaire et le renforcement des capacités;
 - la **politique publique saine**, lorsque les mesures prises par le gouvernement dans les secteurs non liés à la santé, comme la politique sur le transport ou le logement, visent, entre autres, à améliorer la santé de la population;
 - le **développement communautaire reposant sur les actifs**, démarche qui responsabilise les individus et les communautés en se concentrant sur les forces des communautés et sur les actifs et les compétences des individus. Cette approche responsabilise les individus et les communautés au lieu de les déresponsabiliser et les traite de façon à ce que leurs capacités et leurs mérites intrinsèques soient reconnus au lieu de les considérer seulement comme des individus aux nombreux problèmes à régler ou comme des clients impuissants dont il faut répondre aux besoins.
- **Nouveaux modèles de gouvernance communautaire pour la santé et le développement humain** : Il se fait au Canada du travail de mobilisation communautaire très intéressant dans le cadre d'initiatives comme les *Collectivités dynamiques* et *Inclusive Cities Canada* qui, toutes deux, s'appuient sur les forces des communautés pour intervenir dans le domaine de la santé et du développement humain. Ces initiatives qui couvrent toutes les dimensions du concept « communauté » au Canada, vont de l'Accord de Vancouver (nouvel accord de développement urbain entre le Canada, la Colombie-Britannique et la ville de Vancouver qui visait également à faire participer de nombreux autres partenaires pour trouver des solutions aux problèmes complexes dans le centre-est de Vancouver) à la petite, mais inspirante communauté crie des Oujé-Bougoumou. Pourtant, malgré des initiatives très positives, des obstacles entravent les progrès, notamment les dispositions constitutionnelles municipales caduques, l'absence d'une vision nationale d'ensemble du développement de communautés en bonne santé, l'absence d'un ensemble complet de programmes universels pour examiner les facteurs déterminants que l'action communautaire peut ensuite renforcer, le manque constant de financement et les approches restrictives à l'égard du financement, l'absence d'infrastructure communautaire pour la gouvernance de la santé et le développement humain, les restrictions de la loi fédérale imposées aux organismes caritatifs dont relève la majorité des actions communautaires, l'épuisement des bénévoles, et le manque d'échanges d'informations utiles sur les programmes réussis, en particulier entre le Canada anglais et le Canada français.
 - **Services sociaux communautaires intégrés** – Les services sociaux intégrés qui coordonnent les interventions individuelles et les services constituent un important sous-ensemble du développement humain communautaire. Leur but est

de fournir au public un accès rationalisé et simplifié aux services, d'accroître l'efficacité, de dispenser de meilleurs soins et d'éliminer le cloisonnement organisationnel traditionnel ou le cloisonnement des programmes. Les modèles de services sociaux intégrés qui ont fait leurs preuves sont, entre autres, les CLSC du Québec et les centres de santé communautaires du Canada anglais, mais malgré les nombreuses preuves de leur succès, les obstacles caractéristiques qui gênent leur expansion sont le financement, les guerres intestines et les conflits idéologiques. La Saskatchewan a connu quelques succès en matière d'intégration des services et une nouvelle initiative de services intégrés, *Enfants en santé Manitoba*, attire actuellement l'attention. Pour conclure la présente section, nous présentons une vision de services sociaux intégrés élaborée à partir du niveau de ménage.

En dernier lieu, nous proposons une vision axée sur une approche nationale à l'appui d'une action communautaire reposant sur les actifs visant la santé de la population et le développement humain.

1. De nombreux déterminants de la santé ont des effets au niveau communautaire, dans les milieux environnants, maisons, écoles, lieux de travail, quartiers, où vivent les gens, où ils apprennent, travaillent et se divertissent.
2. Les communautés – même celles qui sont les plus défavorisées et qui doivent relever d'immenses défis comme la communauté crie d'Oujé-Bougoumou décrite dans notre rapport – témoignent de forces, de capacités, d'actifs importants, parfois étonnants, qu'elles peuvent utiliser pour résoudre leurs problèmes et améliorer leur santé, leur bien-être et le développement humain.
3. Les gouvernements fédéral et provinciaux, les organisations philanthropiques et le secteur privé seraient bien avisés de reconnaître les forces inhérentes des communautés et de prendre appui sur la capacité communautaire et de la renforcer en investissant dans une stratégie de développement communautaire reposant sur les actifs.
4. Une telle stratégie nécessite, entre autres :
 - a. de reconnaître le rôle vital que jouent les administrations municipales dans la création des conditions favorables à la santé et au développement humain, d'en faire des partenaires clés, et de renforcer leurs pouvoirs (y compris leur pouvoir de taxation);
 - b. d'adopter une approche pangouvernementale globale à l'égard des questions liées à la santé de la population et au développement humain à tous les niveaux du gouvernement, du niveau fédéral au niveau local;
 - c. d'encourager et de soutenir la création de processus et de structures de gouvernance communautaire qui permettent aux nombreux intervenants dans la communauté - le secteur communautaire, les secteurs public, privé, et sans but lucratif, ainsi qu'à chaque citoyen - de reconnaître et de définir les enjeux et problèmes communautaires locaux, de trouver des solutions, et d'élaborer des stratégies à long terme qui reposent sur les actifs visant à les aborder.

5. Pour ce faire, il faut que les gouvernements et les organisations philanthropiques s'engagent à financer à long terme cette infrastructure de gouvernance communautaire. Cela signifie, plus précisément, qu'ils doivent s'engager à fournir moins de financement ciblé à court terme et plus de financement général à long terme que les communautés pourront utiliser de la façon qu'elles jugent utile pour régler les difficultés qu'elles ont définies et développer la capacité communautaire dont elles ont besoin.
6. Tant au niveau national que provincial, il est nécessaire d'établir des organismes nationaux et/ou provinciaux (ou lorsqu'ils sont déjà établis, de les renforcer sensiblement) capables de favoriser la création d'écoles, de lieux de travail et de communautés en bonne santé. Ces organismes pourraient faciliter et soutenir la création d'infrastructures de gouvernance communautaire, mener de la recherche, mettre en commun leurs connaissances et leur expérience, élaborer des outils et « former les formateurs ».
7. Tout travail effectué au niveau national pour améliorer la santé de la population et le développement humain par le biais de l'action communautaire visant à créer des communautés en meilleure santé doit inclure un effort national d'élaboration de nouvelles mesures du progrès, pour nous permettre de suivre l'évolution des progrès dans la réalisation de ces vastes objectifs sociétaux. Ces nouvelles mesures doivent pouvoir s'appliquer à tous les niveaux, du niveau national au niveau local, et elles doivent être élaborées en partenariat avec la communauté, dans le cadre du renforcement de la capacité de la communauté de se comprendre et de comprendre la situation, condition préalable à toute intervention.
8. Les gouvernements devraient mettre en place des systèmes de services de développement humain mieux intégrés comme élément du renforcement de la capacité communautaire (ou comme élément d'appui sur cette capacité). Dans les communautés défavorisées, en particulier, ces services devraient être situés près des personnes qui les utilisent ou qui en ont besoin; ils devraient être faciles à trouver (« accessibles à partir d'un même point ») et à utiliser et, le cas échéant, être logés dans une seule installation qui maximise l'utilisation de l'espace commun pendant la journée.

1. Introduction

Sous l'angle de l'évolution, les êtres humains sont des animaux sociaux. Nous avons évolué au sein de familles et de groupes sociaux plus larges, et l'interaction sociale fait partie intégrante de notre bien-être. La recherche épidémiologique a montré, de façon constante, que l'isolement et la solitude nuisent à la santé. Aussi, contrairement aux souhaits de certains idéologues, la communauté et la société sont des entités bien réelles et on ne peut parler de la santé des individus, la comprendre ou prendre des mesures à son égard si l'on ne reconnaît pas ce fait.

Nous avons fondé notre rapport sur la reconnaissance que la « communauté » est le creuset où agissent de nombreux déterminants de la santé importants. En tant qu'endroit où nous vivons, où nous apprenons, nous travaillons et nous nous divertissons – nos maisons, nos écoles, nos lieux de travail et nos quartiers – il s'agit de notre environnement physique le plus proche¹; en tant que réseau de relations sociales fondé sur ces lieux, mais se prolongeant au-delà dans des communautés virtuelles « non spatiales », il s'agit d'une source fondamentale de notre identité et de notre mieux-être social, et son importance vient juste après celle de notre famille.

Cela ne veut pas dire que la « communauté » soit une panacée, ni qu'il faille l'idéaliser. Les communautés, en tant que lieux et réseaux de relations sociales, peuvent agir en faveur ou au détriment de la santé; en fait, la protection qu'une communauté fournit à ses membres – en particulier les plus vulnérables – contre les préjudices que peuvent leur causer leur environnement physique, social, économique et autres environnements, est en partie ce qui lui permet d'être une communauté saine.

Cela ne veut pas dire non plus que la communauté soit la seule responsable de la bonne santé (ou de la maladie). Nous savons, en fait, que d'un côté, la santé dépend de notre patrimoine génétique et, de l'autre, de la santé des écosystèmes régionaux et de l'écosystème global qui constituent nos « systèmes de support vital ». Tout comme le fameux congressman américain « Tip » O'Neill l'a fait remarquer dans sa célèbre formule « Toute politique est locale », nous pourrions nous aussi dire que toute santé est locale.

L'examen de l'ensemble des déterminants de la santé définis par le Sous-comité sénatorial sur la santé des populations renforce cette idée. L'an dernier, le Sous-comité a publié quatre rapports approfondis examinant divers aspects des politiques sur la santé de la population. Ces rapports établissaient clairement que de multiples facteurs et conditions – ou « déterminants » – ont des effets positifs ou négatifs sur la santé des Canadiens. Les rapports du Sous-comité définissaient les 12 déterminants de la santé suivants²: ceux qui sont suivis d'un astérisque interviennent largement dans les

¹ Il faut se souvenir que 80 % de la population canadienne vit en milieu urbain et qu'elle passe 90 % de son temps à l'extérieur (et un autre 5 % dans un véhicule). ce qui veut dire que l'environnement bâti est de loin notre environnement le plus proche et le plus important. Il ne faut pas oublier non plus que nous faisons également partie des écosystèmes régionaux et de l'écosystème global et que leurs systèmes de support vital influent profondément sur notre bien-être ultime.

² Nous utilisons ici la liste des déterminants de la santé du Sous-comité sénatorial, mais elle diffère légèrement de celles qui ont été établies récemment par d'autres sources canadiennes. L'Agence de la santé publique du Canada utilise sept catégories générales: l'environnement socioéconomique, les environnements physiques, le développement de la petite enfance, les habitudes personnelles de santé, la

communautés canadiennes – les cités, villes, quartiers et régions où les Canadiens vivent, apprennent, travaillent et se divertissent :

- le développement de la petite enfance; *
- le niveau d'instruction;*
- l'emploi et les conditions de travail;*
- le revenu et la situation sociale;*
- les environnements sociaux;*
- les environnements physiques;*
- les réseaux de soutien sociaux;*
- les habitudes de vie et la capacité d'adaptation;*
- le patrimoine biologique et génétique
- le sexe
- la culture (* - peut avoir une importante dimension communautaire)
- les services de santé*

Comme l'a noté le Sous-comité dans son quatrième rapport en avril 2008, certaines études indiquent que la santé de la population dépendrait à 15 % de facteurs biologiques et génétiques, à 10 % de l'environnement physique, à 25 % de l'effet réparateur du système de santé. Autant que 50 % de la santé de la population serait attribuable aux conditions socioéconomiques. Cela veut dire, du fait que la communauté représente aussi l'environnement physique bâti où les Canadiens passent presque tout leur temps et où les services de santé locaux sont fournis, que plus de 75 % des déterminants de la santé influent sur la population canadienne dans le contexte communautaire, à savoir dans nos maisons, dans nos écoles, dans nos quartiers, dans nos lieux de travail, dans nos villes et dans nos cités.

En outre, les conditions nécessaires à la bonne santé sont souvent créées au niveau local, par le travail des administrations municipales, des conseils de bande, des ONG locales ou des organisations du secteur privé ou, dans certains cas, par l'intermédiaire des bureaux régionaux des gouvernements fédéral et provinciaux.

Nous faisons valoir dans notre rapport que puisque de si nombreux déterminants exercent leur influence au niveau local, c'est à ce niveau qu'il faut intervenir. Que pouvons-nous donc faire pour aborder les déterminants de la santé au niveau communautaire, ou du moins certains d'entre eux? Que fait-on actuellement dans les communautés

capacité d'adaptation individuelle, le patrimoine génétique et biologique; et les services de santé. Le groupe de travail FPT sur la santé de la population utilise les déterminants suivants : le revenu, le niveau de scolarité, l'emploi, le logement et l'environnement bâti, l'environnement naturel, les expériences durant la petite enfance, l'alphabétisation, le soutien social, les choix en matière de santé, l'accès aux services de santé préventive et la capacité générale des gens de contrôler les décisions dans leurs propres vies.

canadiennes? Comment les gouvernements fédéral, provinciaux et territoriaux appuient-ils ou promeuvent-ils l'action communautaire visant la bonne santé de la population et le développement humain?

Il importe de noter que le rapport sur l'état de la santé publique au Canada de 2008, premier Rapport annuel de l'administrateur en chef de la santé publique du Canada, demandait explicitement de renforcer la capacité des communautés canadiennes pour aborder les déterminants de la santé, faisant remarquer que les personnes qui vivent le plus près du problème sont aussi souvent celles qui sont le plus près de la solution. Il indique dans son rapport qu'il faut rendre hommage aux communautés et les aider à élaborer leurs propres réponses, à faire fond des connaissances, de l'expérience et de l'énergie présentes sur le terrain. Cette recommandation a trouvé son écho dans le rapport sur les déterminants sociaux de la santé de 2008 de l'OMS qui préconisait, dans l'une de ses principales recommandations, de mettre la santé et l'équité en santé au cœur de la planification et de la gouvernance des villes, en particulier lorsque la pauvreté ou les mauvaises conditions de vie influent sur la santé des populations. De plus, un document de base du processus de recherche factuelle de l'OMS, *Our Cities, Our Health, Our Future : Acting on social determinants for health equity in urban settings*, indiquait que « le développement urbain et la planification urbaine sont indispensables à la création d'environnements physiques et sociaux favorables à la santé et à l'équité en santé ». Il constatait que le secteur de la santé devait établir des partenariats avec d'autres secteurs et avec la société civile pour mener un vaste éventail d'interventions.

2. Aperçu du développement humain sain

« *Salus populi suprema lex* »

(*Le salut du peuple est la loi suprême*)

Cicéron - *De Legibus* (45 ans avant J.-C. environ)

Le but ultime de la gouvernance d'une société est le bien-être de ses membres; il s'agit d'une vérité ancienne dont on fait souvent peu de cas. On trouvera dans l'encadré 1 certaines propositions fondamentales qui devraient constituer les fondements de la promotion de la santé des populations et d'un développement humain sain au niveau local.

Premièrement, la santé de la population est un élément fondamental d'un concept plus vaste, à savoir le développement humain, et l'amélioration de la santé de la population est incluse dans une tâche plus large, à savoir, chercher à s'assurer que tous les individus développent de façon optimale leur potentiel humain.

Deuxièmement, cette tâche est, ou devrait être, l'objectif central du gouvernement. L'Organisation des Nations Unies a elle-même déclaré que « l'être humain est le sujet central du processus de développement » (Déclaration des Nations Unies sur le droit au développement, 1986) et elle en a fait le point central de son Indicateur du développement humain.

Pourtant, curieusement, le développement humain est rarement, de façon explicite, au cœur des activités du gouvernement; celles-ci sont plus souvent axées, semble-t-il, sur le développement économique, ce que résume la phrase fameuse de Bill Clinton, rappel à lui-même durant la course à la présidence : « It's the economy, stupid! » [C'est

l'économie, stupide!]. Nous faisons valoir dans notre rapport que l'économie est un moyen d'arriver à une fin, qui est le développement humain plutôt que le développement économique [ce sont les gens, stupide!] ou, comme l'indique de façon plus éloquente un rapport sur la santé humaine et les écosystèmes de l'Association canadienne de la santé publique en 1992 :

« Le développement humain et la réalisation du potentiel humain exigent une forme d'activité économique qui soit socialement et environnementalement viable pour les générations présentes et à venir ».

Troisièmement, le développement humain est une fonction, non seulement du développement économique, mais aussi du développement social et du développement durable de l'environnement naturel et de l'environnement bâti.

Le quatrième point fondamental est que c'est là où les gens vivent – dans leurs maisons, leurs écoles, leurs lieux de travail, leurs lieux de loisir, leurs quartiers et leurs communautés – que la santé s'acquiert et que les êtres humains se développent. C'est dans ces lieux que les gens peuvent se mobiliser utilement, et où les promesses de la promotion de la santé – « processus qui confère aux populations les moyens d'assurer un plus grand contrôle sur leur propre santé, et d'améliorer celle-ci » (OMS, 1986) – peuvent se réaliser le plus facilement.

Un cinquième point fondamental est que, non seulement le développement humain devrait être au cœur des activités des gouvernements (tous les ordres), mais aussi de la gouvernance. Le Centre des Nations Unies pour les établissements humains définit la gouvernance (dans le contexte de la gouvernance urbaine) comme étant

« la somme des nombreuses façons dont les individus et les institutions, publiques et privées, gèrent leurs affaires communes ».

Cette approche, bien entendu, devrait être appliquée à tous les ordres de gouvernement. Ce qu'il y a d'important dans cette définition est que, quel que soit l'ordre de gouvernement auquel on l'applique, la gouvernance nécessite la participation des individus et celle des institutions publiques et privées. Ensemble, ils participent à la planification et à la gestion de leurs affaires communes, probablement dans un but commun. Quel objectif commun est-il plus noble que d'assurer que tous les membres de la société et de la communauté atteignent le niveau de santé, de mieux-être et de développement humain le plus élevé possible? Qui peut douter que dans une telle situation, non seulement les individus, mais également les communautés et les entreprises, pourraient prospérer?

Sixièmement, les communautés ou, au sens politique, les municipalités, sont particulièrement importantes parce qu'elles représentent l'ordre de gouvernement le plus proche des gens, et qu'elles englobent les autres milieux environnants. Il en résulte qu'il faut donner à la gouvernance de la santé et du développement humain une dimension locale importante, tout en tenant compte de l'importance que le gouvernement fédéral et les provinces aient des politiques et des programmes qui l'appuient.

Septièmement, un système intégré de services sociaux communautaires est un élément important du développement humain local. On pourrait créer ce genre de système à partir du niveau du ménage, en cherchant des moyens de favoriser le développement humain à

tous les niveaux et dans toutes ses dimensions, sous l'angle de chaque citoyen, nourrisson, enfant, jeune, adulte ou aîné.

Encadré 1 : Certaines propositions fondamentales pour la promotion de la santé de la population et le développement humain sain au niveau local

Certains concepts fondamentaux sous-tendent les fondements de la promotion de la santé communautaire. Ces fondements ont trait à la promotion du développement humain sain :

1. La santé de la population est un élément fondamental qui s'inscrit dans le concept plus large du développement humain sain pour que tous les individus développent de façon optimale leur potentiel humain.
2. La tâche de promouvoir le développement humain optimal est – ou devrait être – l'objectif premier de tous les ordres de gouvernement. Ceux-ci devraient consacrer la même attention et la même énergie au développement de la population qu'ils consacrent au développement économique du pays.
3. Le développement humain est un résultat non seulement d'un développement économique stable et efficace, mais également du développement social et du développement durable de l'environnement naturel et de l'environnement bâti.
4. C'est là où les gens vivent – dans leurs maisons, leurs écoles, leurs lieux de travail, leurs lieux de loisir, leurs quartiers et leurs communautés – que la santé s'acquiert et que les êtres humains se développent.
5. Bien que les gouvernements jouent un rôle important, la création des conditions pour un développement humain sain exige un système de gouvernance élargi et plus inclusif dans tous les ordres de gouvernement.
6. Par conséquent, les communautés – ou, au sens politique, les municipalités – sont particulièrement importantes parce qu'elles sont l'ordre de gouvernement le plus proche des gens, et qu'elles contiennent les autres milieux environnants. Il en résulte que la gouvernance de la santé et du développement humain doit avoir une forte dimension locale et tenir également compte de l'importance des politiques et des programmes fédéraux et provinciaux qui la soutiennent.
7. Un système intégré de services sociaux communautaires est un élément important du développement humain local. On pourrait créer un système de développement humain communautaire au niveau local idéal en partant du niveau du ménage et il serait soutenu à chaque niveau et à partir de chaque dimension, sous l'angle de chaque citoyen et de ses besoins, qu'il s'agisse du nourrisson, de l'enfant, du jeune, de l'adulte ou de l'aîné.
8. Parallèlement, ce genre de système communautaire idéal devrait être fondé sur le respect de la capacité et de l'autonomie des individus et des communautés, et il doit responsabiliser, non déresponsabiliser, et habiliter. Il doit s'appuyer sur la capacité des individus et des communautés de reconnaître leurs propres besoins et d'y répondre.

En dernier lieu, un tel système doit être fondé sur la capacité (qu'il doit respecter) des individus et des communautés, qu'il doit responsabiliser, et non déresponsabiliser, habiliter et non déshabiliter; il doit faire fond sur cette capacité.

Nous illustrons notre rapport par des exemples et des cas concrets qui montrent clairement qu'il ne s'agit pas de chimères, mais d'idées applicables. Même si le système

que nous décrivons n'existe pas encore complètement, un grand nombre de ses éléments, sinon tous, existe déjà quelque part au Canada ou ailleurs dans le monde.

2.1 · Santé de la population et développement humain

La santé, a déclaré il y a 60 ans l'Organisation mondiale de la santé, dans une phrase devenue célèbre, est un état complet de bien-être physique, mental et social. L'inclusion du bien-être social signale que le contexte social de l'individu a une grande importance, que la santé dépend, du moins en partie, des liens sociaux. Au fil des ans, la liste des éléments dont la santé dépend – les déterminants de la santé – s'est considérablement allongée. Selon le fameux Rapport Lalonde de 1974, il existe quatre groupes de facteurs qui influent sur la santé » – les habitudes de vie, l'environnement (physique, social et économique), les services de santé et le patrimoine biologique – et toute amélioration future de la santé des Canadiens dépendrait principalement des deux premiers. Plus récemment, le Programme de recherche sur la santé de la population de l'Institut canadien de recherches avancées puis le Comité consultatif (canadien) sur la santé de la population ont ajouté des éléments à cette liste qui compte aujourd'hui un ensemble de 12 déterminants reconnus par le Sous-comité sénatorial sur la santé des populations.

C'est toutefois la Charte d'Ottawa pour la promotion de la santé adoptée en 1986 par l'OMS qui a fait remarquer que la santé n'est pas le but ultime de la vie, mais qu'il s'agit plutôt d'une ressource de la vie quotidienne, et non du but de la vie, qu'une « bonne santé est une ressource majeure pour le progrès social, économique et individuel, tout en constituant un aspect important de la qualité de vie ». La santé, alors, n'est qu'un élément d'une vie bien remplie ou d'une bonne vie, qu'une partie de ce à quoi nous aspirons.

Cela nous amène à nous demander à quoi nous devrions aspirer pour les êtres humains. On pourrait répondre, que chacun d'eux se développe de façon optimale et réalise tout son potentiel, en tenant compte du fait que chaque personne possède un potentiel différent, et que ce potentiel inclut de mener son existence dans un état complet de bien-être physique, mental et social, et qu'il transcende même cela. Le Centre for Human Potential and Public Policy de l'Université de Chicago définit le potentiel humain de la façon suivante :

« la motivation, l'intelligence humaine, le développement social et émotionnel, l'éthique et la moralité, et un sens de responsabilité civique »
(www.harrisschool.uchicago.edu/research/chppp/)

On pourrait ajouter à cette liste la créativité et la capacité d'innovation, le sentiment d'empathie et de sollicitude à l'égard d'autrui (y compris les espèces non humaines et la nature dans son ensemble). Le développement de ce type de potentiel humain pour tous est un objectif ambitieux, mais méritoire; il reconnaît qu'un objectif est, comme l'a indiqué le Service de la santé publique des États-Unis il y a une trentaine d'années « une déclaration d'aspiration intemporelle ».

Parmi les efforts faits ces vingt dernières années pour comprendre le développement humain, l'élaboration de l'Indicateur du développement humain par le Programme des Nations Unies pour le développement (PNUD) (voir l'encadré 2) représente l'un des efforts, reconnus mondialement, qui a la plus grande portée. Il est remarquable de

constater le degré dans lequel ce travail tient compte à la fois d'une approche fondée sur les « déterminants de la santé » et le concept du potentiel humain.

Encadré 2 : Développement humain – concepts de base et définition

Le développement humain est un paradigme du développement qui valorise beaucoup plus que la simple hausse ou la baisse des revenus nationaux. Il repose sur la création d'un environnement au sein duquel les gens peuvent développer pleinement leur potentiel et mener des vies productives et créatives en accord avec leurs besoins et leurs intérêts. Les gens sont la vraie richesse des nations. Le développement vise donc à élargir les choix qui s'offrent aux personnes pour leur permettre de mener des vies qui leur sont précieuses. Il s'agit donc de bien plus qu'une croissance économique, qui n'est qu'un moyen — certes très important — d'élargir les choix qui s'offrent aux populations.

L'élargissement de ces choix repose sur un élément essentiel : la construction des capacités humaines, c'est-à-dire l'éventail de choses que les gens peuvent faire ou être dans la vie. Les capacités les plus fondamentales pour le développement humain consistent à mener des vies caractérisées par la longévité et la santé, l'accès au savoir, l'accès aux ressources nécessaires pour atteindre un niveau de vie décent et à être en mesure de prendre part à la vie de la communauté. Sans cela, de nombreux choix ne sont tout simplement pas disponibles et de nombreuses opportunités dans la vie restent inaccessibles.

« Le principal objectif du développement est d'élargir les choix qui s'offrent aux gens. En principe, ces choix peuvent être infinis et peuvent varier dans le temps. Les gens attachent souvent de la valeur aux réussites qui ne transparaissent pas du tout, ou pas immédiatement, dans les chiffres relatifs aux revenus ou à la croissance économique : un meilleur accès aux connaissances, une meilleure nutrition et de meilleurs services de santé, des moyens d'existence plus sûrs, une certaine sécurité contre la criminalité et la violence physique, du temps libre bien rempli, des libertés politiques et culturelles et un sentiment de participation aux activités de la communauté. L'objectif du développement est de créer un environnement favorisant l'épanouissement pour que les gens puissent jouir d'une vie longue, saine et créative ».

Mahbub ul Haq, Fondateur du Rapport mondial sur le développement humain

Cette vision du développement, souvent oubliée dans le souci immédiat d'accumuler des marchandises et une richesse financière, n'est pas nouvelle. Les philosophes, les économistes et les responsables politiques conçoivent depuis longtemps le bien-être des gens comme l'objectif et la finalité du développement. Comme l'a écrit Aristote dans la Grèce antique, « Évidemment, la richesse n'est pas le bien dont nous sommes en quête; la richesse n'est qu'une chose utile et recherchée en vue de choses autres qu'elle-même. »

« Le développement humain est un processus d'élargissement des choix offerts aux gens. Élargir les choix des gens devient une réalité à travers le développement des capacités humaines et des modes de fonctionnement humain fondamentaux. À tous les niveaux du développement, les trois capacités essentielles du développement humain sont la longévité et la santé, le savoir et un niveau de vie décent. Si ces capacités fondamentales ne sont pas réalisées, de nombreux choix ne sont tout simplement pas disponibles et de nombreuses opportunités demeurent inaccessibles. Cependant, le domaine du développement humain s'étend au-delà : les domaines essentiels du choix, auquel les gens attachent beaucoup d'importance, vont des opportunités politiques, économiques et sociales permettant d'être créatif et productif, jusqu'à l'appréciation de l'estime de soi, de l'émancipation et du sens d'appartenance à une communauté. Le développement humain est un concept holistique, car il met les individus au centre de tous les aspects du processus de développement. Il a souvent été erronément interprété et confondu avec les approches et concepts suivants du développement ».

Glossaire des Rapports sur le développement humain du PNUD

*Source : Rapports sur le développement humain, Programme des Nations Unies pour le développement;
<http://hdr.undp.org/fr/devhumain>*

2.2 Le « droit » au développement humain

« Le développement humain est un concept holistique, car il met les individus au centre de tous les aspects du processus de développement ».

Glossaire des Rapports sur le développement humain du PNUD

Reconnaissant la position centrale de la dimension humaine dans le développement, l'Assemblée générale des Nations Unies a adopté en 1986 une « Déclaration sur le droit au développement » qui indique que « l'être humain est le sujet central du développement » et demande aux États membres « d'assurer [...] l'accès aux ressources de base, à l'éducation, aux services de santé, à l'alimentation, au logement, à l'emploi et à la répartition équitable du revenu » (Développement humain durable. Commission économique des Nations Unies pour l'Afrique, 1995).

Un an plus tard, la Commission mondiale sur l'environnement et le développement a défini le développement durable en mettant fortement l'accent sur l'exigence de répondre aux besoins des gens :

« On entend par développement durable un développement qui répond aux besoins actuels sans nuire à la capacité des générations futures de répondre aux leurs ». (CMED, 1987)

Cet accent mis sur le développement humain était encore plus fortement marqué à la Conférence sur l'environnement et le développement des Nations Unies tenue à Rio de Janeiro en 1992. Le premier principe de la Déclaration de Rio est le suivant :

« Les êtres humains sont au centre des préoccupations relatives au développement durable. Ils ont droit à une vie saine et productive en harmonie avec la nature ».

Bien qu'initialement axé sur le développement économique environnementalement durable, le concept a été élargi pour inclure la notion de société durable (Table ronde de la C.-B. sur l'environnement et l'économie, 1993). Il est donc devenu courant de considérer la durabilité en termes de « piliers » ou de « sphères » ou de formes de « capital », à savoir, les éléments économiques, sociaux et environnementaux. C'est l'interaction de ces trois éléments qui détermine le niveau de développement humain, qui est une quatrième forme de « capital » (Ekins, Mayer et Hutchinson, 1992; Banque mondiale, 1995). Par conséquent, il faudrait considérer la santé, la qualité de vie et le développement humain comme des mesures des indicateurs de résultats d'une activité économique socialement et environnementalement durable réussie.

Ces concepts sont intégrés dans un rapport d'un groupe de travail de l'Association canadienne de santé publique sur la santé humaine et de l'écosystème publié en 1992 dans lequel il déclare :

« Le développement humain et la réalisation du potentiel humain exigent une forme d'activité économique qui soit socialement et environnementalement viables pour les générations présentes et à venir ».

Alors que le Sommet mondial pour le développement social, tenu également en 1995, notait que

« Nous sommes profondément convaincus de l'interdépendance du développement économique, du développement social et de la protection de l'environnement. Nous savons aussi que ces éléments agissent les uns sur les autres pour réaliser le développement durable. Or, ce développement durable constitue le cadre de notre action pour assurer à tous une meilleure qualité de vie ». (*Cité dans Santé Canada, 2000*)

2.3 Création du capital communautaire – Les cinq formes de capital

Tandis que les êtres humains devraient être au centre de toutes les formes de développement, le sujet central du développement humain – comme nous l'avons noté dans l'introduction de cette section – devrait être la communauté dans laquelle ils vivent et mènent leur existence; meilleure est la communauté et meilleurs sont la santé, le bien-être et le niveau de développement humain des personnes qui y résident. Un objectif prioritaire devrait consister à mettre la personne au centre du développement communautaire, et mettre le développement communautaire et humain au centre de la politique publique et de la gouvernance sociétale.

La Figure 1, qui est une version récemment élaborée d'un modèle conceptuel initialement développé relativement au concept de ville ou de communauté saine (Hancock, 1993) et très largement utilisé, montre une façon de le comprendre. Le modèle utilise le concept de « capital communautaire » qui est la combinaison de la « richesse » totale de la communauté, ainsi que le concept des quatre formes de capital indiquées ci-dessus en y ajoutant une cinquième forme de capital, le « capital bâti » qui est aujourd'hui le modèle dominant des Canadiens³. Ce modèle montre :

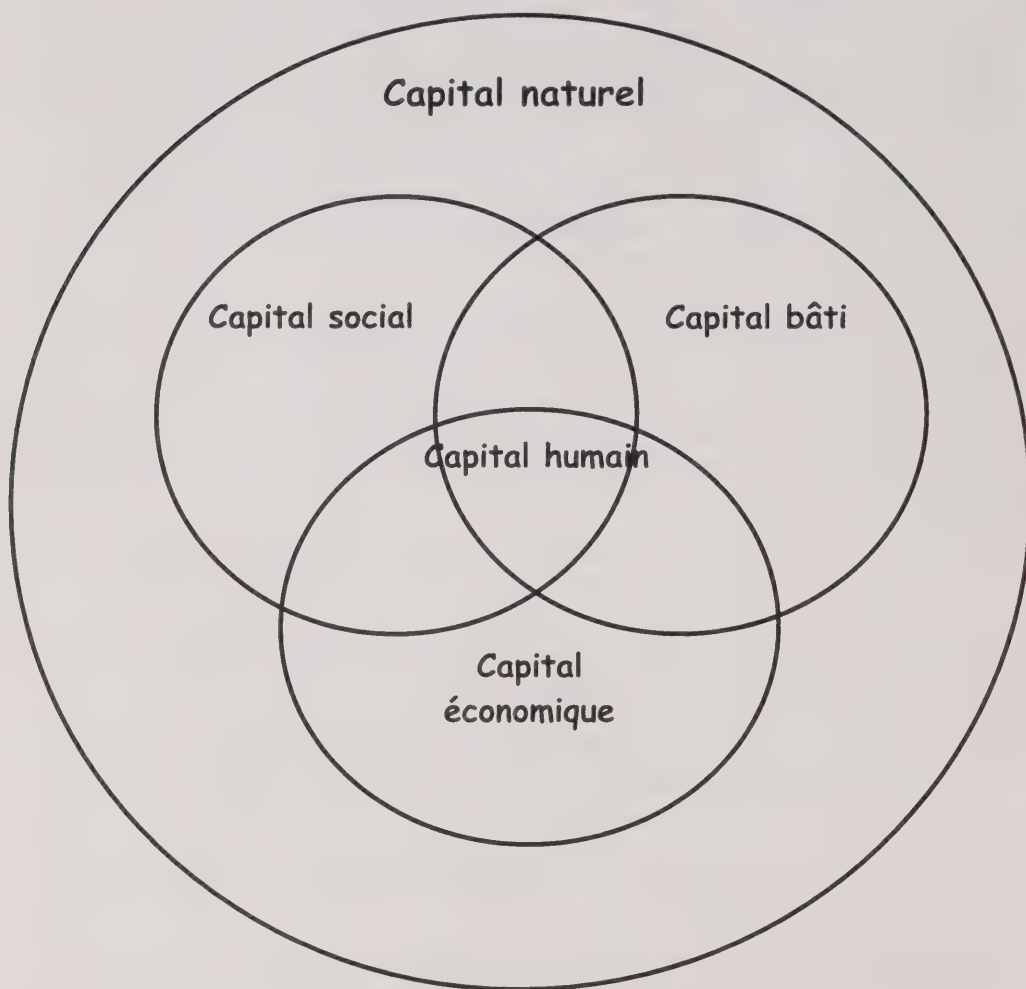
- que le développement humain est le produit de l'interaction du capital bâti, du capital économique et du capital social, dans le contexte du capital naturel;
- que, conceptuellement, plus il y a d'intégration (chevauchement) dans le développement de capital social, de capital économique ou de capital bâti, plus le niveau de capital humain est élevé;
- qu'il est nécessaire d'établir un certain équilibre entre toutes ces formes de capital et, notamment, qu'il n'est pas viable de créer une forme de capital en épuisant d'autres formes de capital;
- que la combinaison de ces formes de capital ne peut excéder le capital naturel (intégrité et santé de l'écosystème, durabilité des ressources, systèmes de support vital, capacité limite).

Il est important de faire la distinction entre le capital social et le capital humain. Le capital humain est la somme des capacités ou potentiel réalisé de chaque individu dans une communauté ou une ville; il est inhérent à l'individu, alors que

³ « Le milieu bâti fait partie de l'écosystème global de la planète Terre. Ce milieu englobe tous les bâtiments, espaces et produits créés ou à tout le moins considérablement modifiés par les humains. En font partie nos maisons, nos écoles, nos lieux de travail, nos parcs, nos quartiers commerciaux et nos routes. Il s'étend par-dessus nos têtes sous forme de lignes de transport d'électricité, sous terre sous forme de décharges et de rames de métro et dans le pays tout entier sous forme de routes ». Santé Canada, Santé et Environnement (1997).

« le capital social n'est pas inhérent à la personne, mais plutôt à la structure des relations entre les personnes ». (Coleman, 1988)

Figure 1 : Capital humain et développement centré sur la personne



Le concept de connexions et de réseaux sociaux informels de Putman (Putnam, 1993), et les idées qui y sont associées, en est venu à dominer le concept de « capital social ». Toutefois, la structure de nos relations avec les autres doit être comprise en fonction de deux autres dimensions au moins :

- le capital social « formel », représenté par le système de programmes sociaux que nous avons créé – pensions, assurance-emploi, soins de santé, aide sociale, services sociaux, éducation publique, etc.;
- le capital social « invisible », représenté par les systèmes constitutionnel, juridique et politique que nous avons créés au fil des siècles et qui régissent nos interactions dans une société démocratique et conformément au principe de légalité, de façons dont on peut ne pas être toujours conscients.

Par conséquent, le développement humain dépend du développement économique et social axé sur la personne et du développement axé sur la personne de l'environnement bâti, et en tenant compte des contraintes imposées par les systèmes naturels. La gouvernance des diverses interactions de ces différentes dimensions, l'atteinte d'un équilibre approprié entre ces dimensions souvent concurrentes de façon à mobiliser les membres de la communauté de tous les secteurs, la maximisation – idéalement – simultanée de toutes ces formes de capital – sont au cœur de l'art de la gouvernance locale de la santé et du développement humain.

Toutefois, d'autres organisations ont aussi utilisé le concept des cinq formes de capital, en le modifiant légèrement. Le ministère du Développement international (MDI) du Royaume-Uni qui dirige l'action du gouvernement britannique contre la pauvreté, préconise largement ce qu'il appelle une « approche fondée sur les moyens de subsistance » qui utilise un cadre axé sur les cinq formes de capital.

Comme il le fait observer, les êtres humains et leur accès aux biens sont au cœur des approches fondées sur les moyens de subsistance. Dans son cadre original, le MDI définit cinq catégories de biens, ou capitaux; d'autres leur ont été ajoutées ultérieurement, notamment le capital politique (pouvoir et capacité d'influencer les décisions). Les cinq catégories initiales de capital sont les suivantes :

- le capital humain : compétences, connaissances, santé et capacité de travailler;
- le capital social : ressources sociales, notamment les réseaux informels, les membres des groupes formalisés et les relations de confiance qui facilitent la coopération;
- le capital naturel : ressources naturelles telles que la terre, le sol, l'eau, les forêts et les ressources piscicoles;
- le capital physique : infrastructure de base, comme les routes, l'eau et l'hygiène publique, les écoles, les TIC; et les biens produits, y compris les outils et l'équipement;
- le capital financier : ressources financières incluant les épargnes, le crédit, et le revenu provenant de l'emploi, du commerce et des envois de fonds.

Le MDI fait remarquer que des actifs peuvent être détruits ou créés par suite des tendances (économiques, politiques), de chocs (guerres, conflits, catastrophes naturelles) et des changements saisonniers qui rendent les individus vulnérables dans leur vie quotidienne. Les politiques, les institutions, les processus peuvent avoir une grande

influence sur l'accès aux biens – en les créant, en en déterminant l'accès, en influant sur les taux d'accumulation d'actifs. Ceux qui possèdent plus d'actifs sont plus susceptibles d'avoir plus de possibilités de moyens de subsistance pour poursuivre leurs objectifs et réduire la pauvreté⁴.

2.4 Nouvelles mesures du progrès

Si l'objectif central du gouvernement – et, en fait, de la gouvernance de la société et de la communauté – est d'améliorer la santé, le bien-être, le développement humain, et la création de capital communautaire, il s'ensuit alors qu'il faudrait mesurer notre progrès en tant que pays, province, territoire, municipalité ou communauté, en ces termes. Nous prenons de plus en plus conscience des limites du système que nous utilisons actuellement pour mesurer le progrès; le PNB, qui est une mesure très imparfaite du bien-être d'une société, est trop souvent la seule chose qui semble compter. Pourtant, dans le monde des indicateurs, il est évident que « nous obtenons ce que nous mesurons » – et que si nous utilisons des mesures imparfaites, nous ne devrions pas être surpris d'obtenir des résultats imparfaits.

Beaucoup de travail a été effectué ces dernières décennies pour élaborer de nouvelles mesures du progrès. D'une façon ou d'une autre, toutes ont tenté d'intégrer la plupart des cinq formes de capital, sinon toutes, et le concept de développement humain indiqués ci-dessus. Nous présentons ici certaines initiatives essentielles qui revêtent une pertinence particulière pour le Canada :

- Indicateur du développement humain (IDH) : Cet indicateur qui a été élaboré par le PNUD est utilisé depuis une vingtaine d'années. Le premier Rapport sur le développement humain (1990) a introduit une nouvelle manière de mesurer le développement en faisant la synthèse des indicateurs d'espérance de vie, de niveau d'études et de revenu, pour aboutir à un indicateur composite du développement humain, l'IDH. Le tournant décisif pour l'IDH fut la création d'une statistique unique destinée à servir de cadre de référence pour le développement économique et social. Au fil du temps, cet indicateur est devenu de plus en plus complexe et raffiné, avec l'ajout de l'Indicateur sexospécifique du développement humain (l'ISDH, qui est l'IDH ajusté en fonction de l'inégalité sexospécifique), de l'Indicateur de la participation des femmes (IPF, mesure de l'égalité sexospécifique en matière de participation économique et politique et de prise de décision) et l'Indicateur de la pauvreté humaine (IPH), qui utilise les indicateurs incorporant les dimensions les plus fondamentales de la privation : une courte espérance de vie, un manque d'instruction fondamental et un manque d'accès aux ressources publiques et privée (consulter le site http://hdr.undp.org/fr/statistiques/indicateurs/isdh_ipf)

Pendant de nombreuses années, le Canada s'est classé en tête ou près de la tête du classement international des pays au chapitre de l'IDH; dans le rapport de 2008 (fondé sur les données de 2006) il se classait au 3^e rang. Toutefois, il

⁴ On trouvera plus d'information sur le MDI sur le site www.dfid.gov.uk. On trouvera d'autres renseignements sur l'approche relative aux moyens de subsistance auprès de l'International development clearinghouse Eldis Organization, www.eldis.org.

s'est classé au 83^e rang des 157 pays visés par l'ISDH (bien que l'écart entre tous les pays soit très mince), et au 11^e rang selon l'IPF⁵. Cependant, au Canada, il existe des différences très marquées entre les Autochtones et les non-Autochtones. Une étude comparant l'IDH pour les Indiens inscrits et le reste de la population canadienne (Cooke, Beavon et McHardy, 2004) a trouvé que l'IDH canadien en 1981 était 0,806 et qu'il a augmenté, s'élevant à 0,880 en 2001⁶, alors que l'IDH pour les Indiens inscrits qui était 0,626 en 1981 a atteint 0,765 en 2001. Bien que l'écart entre les deux populations se soit rétréci, passant de 0,23 en 1981 à 0,11 en 2001, un résultat de 0,765 a placé les Indiens inscrits au même niveau que le Kazakhstan, qui s'est classé au 76^e rang des 175 pays en 2001 (PNUD, 2003).

- Indicateur de progrès réel (IPR) : fondé sur les travaux de Herman Daly et John Cobb (1989) qui ont mis au point l'Indice du bien-être économique, l'IPR a été créé par Redefining Progress, organisation située à San Francisco, en 1995. « L'IPR utilise les mêmes données de la consommation personnelle sur lesquelles se fonde le PIB, mais il fait des distinctions importantes. Il tient compte de facteurs tels que la répartition du revenu, ajoute des facteurs tels que la valeur du travail ménager et du travail bénévole, et en soustrait d'autres comme les coûts associés à la criminalité et à la pollution »⁷. On peut l'utiliser aux niveaux national, provincial ou local.

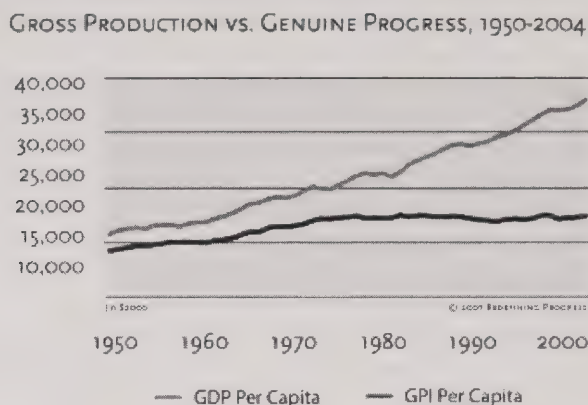
L'IPR utilise les mesures suivantes : la répartition du revenu, le travail ménager, le travail bénévole et les études supérieures; la criminalité, l'épuisement des ressources, la pollution; le dommage environnemental à long terme, les changements concernant le temps consacré aux loisirs; les dépenses consacrées à la défense de l'environnement; la durée de vie des produits de consommation durables, l'infrastructure publique, et la dépendance à l'égard des biens étrangers.

La différence entre le PIB et l'IPR est très révélatrice; les comptes annuels du PIB et de l'IPR pour les É.-U. de 1950 à 2004 (la plus récente mise à jour faite par Redefining Progress) révèle la vérité qui se cache derrière la phrase « obtenir de meilleurs résultats, mais se sentir pire ». Bien que le PIB ait augmenté régulièrement, l'IPR stagne depuis les années 1970 (voir la Figure 2).

⁵ http://hdrstats.undp.org/2008/countries/country_fact_sheets/cty_fs_CAN.html

⁶ Curieusement, le PNUD a donné au Canada une cote de 0,937 en 2001, ce qui l'a placé au 8^e rang; une cote de 0,880 l'aurait placé au 29^e rang à côté de la Slovaquie. Il est clair qu'il existe des différences méthodologiques entre l'estimation de l'IDH du PNUD et celle des auteurs canadiens.

⁷ www.rprogress.org/sustainability_indicators/genuine_progress_indicator.htm

Figure 2 : PIB et IPR, États-Unis, 1950 - 2004

Production brute c. progrès réel, 1950-2004

PIB par habitant IPR par habitant

Au Canada, GPI Atlantic a élaboré l'IPR au niveau provincial pour la Nouvelle-Écosse et a mis à l'essai sa mise en œuvre au niveau communautaire dans trois communautés de la Nouvelle-Écosse - Kings County, Glace Bay et Halifax⁸, tandis que le Pembina Institute élaborait l'IPR pour l'Alberta en 2000 et le mettait à jour en 2005⁹.

- **Bonheur national brut (BNB)** : Proposé par le roi du Bhoutan dans les années 1970, le BNB exprime la notion bouddhiste que le but ultime de la vie est le bonheur intérieur. L'indice de BNB est un seul chiffre visant à « traduire le bonheur et le bien-être général de la population bhoutanaise » et on le calcule au moyen des trois ensembles généraux d'indicateurs; indicateurs du niveau de BNB, indicateurs géographiques du BNB et indicateurs de corrélation et de cause à effet du BNB. Les indicateurs du BNB comprennent neuf dimensions de base :
 - le bien-être psychologique
 - l'utilisation du temps
 - la vitalité de la communauté
 - la culture
 - la santé
 - l'éducation
 - la diversité environnementale
 - le niveau de vie

⁸ www.gpiatlantic.org/community.htm

⁹ www.greeneconomics.ca/AlbertaGPI

- la gouvernance¹⁰

Ces dernières années, le BNB a attiré l'attention au niveau international, et la Seconde conférence internationale sur le BNB a été tenue en Nouvelle-Écosse en 2005, avec l'appui financier du CRDI et de l'ACDI et le soutien de nombreux partenaires, y compris de GPI Atlantic¹¹. Les chercheurs affiliés à GPI Atlantic ont travaillé avec les chercheurs du Bhoutan et ils ont récemment entrepris (printemps 2009) une enquête-pilote sur le BNB à Victoria (C.-B.) dans le cadre d'une série d'enquêtes-pilotes de ce type dans plusieurs pays (Mike Pennock, communication personnelle).

- Indice canadien du mieux-être (ICME) : L'Atkinson Charitable Foundation travaille avec un nombre d'organisations et de communautés du Canada depuis 1999 pour mettre au point l'ICME. Elle crée, en particulier, des partenariats avec les Fondations communautaires du Canada concernant leur initiative des signes vitaux et avec l'initiative de revitalisation des quartiers de Centraide, et elle a aussi des liens avec l'initiative de rapports de la qualité de vie de la FCM¹² ainsi qu'avec Communautés dynamiques. L'indice a huit domaines - assez semblables à ceux du BNB - qui seront combinés pour former un indicateur composite :

- populations saines
- vitalité de la communauté
- utilisation du temps
- population scolarisée
- santé de l'écosystème
- arts et culture
- engagement civique
- niveau de vie

« Plus important, l'ICME mettra en lumière l'interdépendance de ces importants domaines ». Comme l'IPR, il « traitera les activités utiles comme des actifs et celles qui sont nocives comme des passifs » et également, tout comme l'IPR, il sera calculé aux niveaux national, provincial, régional et communautaire¹³.

On constate clairement un intérêt croissant à tous les niveaux, du niveau international au niveau local, envers l'élaboration d'autres options de mesure du progrès: en outre, un

¹⁰ www.grossnationalhappiness.com/gnhIndex/introductionGNH.aspx

¹¹ www.gpiatlantic.org/conference/

¹² Dirigé par la Fédération canadienne des municipalités (FCM), le Système de rapports sur la qualité de vie (SRQDV) évalue, surveille et diffuse les tendances sociales, économiques et environnementales observées dans les plus grandes villes et collectivités du Canada. Le Système de rapports sur la qualité de vie est une initiative portée par ses membres. Au nombre de 16 en 1996, les collectivités membres du SRQDV sont maintenant 23, réparties dans sept provinces. (Source : <http://www.fcm.ca/Francais/view.asp?x=477>)

¹³ www.atkinsonfoundation.ca/ciw

grand nombre de ces efforts ont de nombreux éléments communs. On a constaté un intérêt particulièrement marqué ces dernières décennies pour le développement d'ensembles d'indicateurs plus généraux au niveau communautaire, notamment des ensembles d'indicateurs pour les communautés saines, les communautés durables, les communautés viables et les communautés sécuritaires, et pour la qualité de vie¹⁴. Tous sont élaborés de façon à tenir compte des communautés de façon globale, souvent en utilisant des catégories de bien-être ou de développement humain, économique, social et environnemental.

En outre, et plus important, ils incluent presque toujours une stratégie de mobilisation communautaire, étant donné que l'élaboration d'indicateurs et leur utilisation par la communauté sont considérés comme un élément important du processus de renforcement de la capacité communautaire.

Tout effort au niveau national pour améliorer la santé de la population et le développement humain par l'action communautaire, afin de créer des communautés plus saines, doit s'accompagner d'un effort national d'élaboration de nouvelles mesures de progrès comme celles dont nous avons parlé ci-dessus, afin que l'on puisse voir les progrès que nous avons réalisés dans l'atteinte de ces vastes objectifs sociétaux. Ces nouvelles mesures doivent pouvoir s'appliquer à tous les niveaux, de l'international au local, et elles doivent être élaborées en partenariat avec les communautés, dans le cadre du renforcement de la capacité de la communauté de se comprendre et de comprendre sa situation, condition préalable nécessaire pour poser des gestes concrets.

2.5 Renforcement de la résilience chez les gens et les communautés

La résilience est un important concept relié au capital communautaire – il s'agit, en quelque sorte, de la somme, à un niveau personnel et communautaire, des créations de toutes les formes de capital communautaire. Dans son récent ouvrage « Shared Space : The Communities Agenda », Sherri Torjman, vice-présidente du Caledon Institute of Social Policy, avance que l'objectif de ce que Paul Born, directeur du Tamarack Institute, appelle le « programme communautaire » est de promouvoir la résilience pour bâtir des communautés fortes et dynamiques (p. 3).

En s'appuyant sur deux domaines de recherche et de pratique très différents mais étonnamment complémentaires – l'écologie et la santé mentale – Torjman avance que « la capacité, non seulement de s'adapter, mais également de prospérer face à des problèmes ardues et au changement continu » (p. 5) – est un attribut souhaitable tant pour les êtres humains que pour les communautés (et, bien entendu, pour les écosystèmes).

En fait, il existe une interrelation entre les personnes résilientes et les communautés résilientes. Il n'est alors pas surprenant, fait valoir Torjman, que pour renforcer la résilience il faille investir dans la capacité personnelle (« les compétences, habiletés et ressources des individus et des ménages ») et dans l'infrastructure communautaire

¹⁴ Voir, par exemple, le Community Indicators Consortium, réseau d'apprentissage et communauté d'expertise pour les personnes engagées dans le domaine des indicateurs communautaire et leur application ou que ce domaine intéresse. Sa septième conférence internationale aura lieu à Seattle à l'automne 2009. (www.communityindicators.net/)

(« l'approvisionnement en produits de base et en ressources qui contribuent au bien-être », p. 18). Plus précisément, cela veut dire d'investir dans :

- la satisfaction des besoins de base (logement abordable convenable, revenu suffisant, protection de la santé);
- le développement des capacités et des compétences d'adaptation de base (développement de la petite enfance, alphabétisation, empathie, résolution des problèmes, et systèmes de soutien social et de capital social);
- la participation active à la vie sociétale et un sentiment de capacité d'action, résultant du discours public, la participation à la prise de décision, le volontarisme, la participation à des activités récréatives – et la création des espaces publics nécessaires pour mener ces activités;
- la création de possibilités au moyen de la formation et du développement des compétences, du développement économique communautaire, et du renforcement des biens collectifs et personnels, publics et privés.

3. Création de communautés plus saines

« [...] la plus grande contribution à la santé de la nation ces 150 dernières années est le fait non pas des médecins ni des hôpitaux, mais de l'administration locale ».

--Dr Jessie Parfitt, dans *The Health of a City : Oxford, 1770-1974*

L'histoire nous enseigne pourquoi il est utile de s'occuper de la santé de la population au niveau communautaire. Comme l'a relevé Thomas McKeown dans son fameux ouvrage publié dans les années 1970 (McKeown, 1978), les gains les plus importants en matière d'espérance de vie et de santé humaines ces 200 dernières années sont attribuables à l'accès à l'eau potable, à de meilleurs réseaux d'assainissement, à une meilleure alimentation et à l'amélioration du niveau de vie, tous se produisant au niveau communautaire, et aucun d'eux n'étant le résultat de meilleurs services de santé per se.

En fait, il existe un lien historique entre la santé et les villes, et le mouvement de santé publique contemporain est né des préoccupations sur la santé des villes en Angleterre au milieu du XIX^e siècle (voir l'annexe 1).

Le mouvement des villes et des communautés saines actuel est né du concept de la promotion de la santé développé au Canada et en Europe au milieu des années 1980, plus précisément, lors d'une conférence sur la politique publique saine tenue à Toronto en 1984 qui a entraîné la création du projet des Villes-Santé par le bureau de l'OMS pour l'Europe en 1986 (voir l'annexe 2). À ce titre, il prend sa source dans les principaux éléments de la *Charte d'Ottawa pour la promotion de la santé* et dans l'approche fondée sur les milieux environnants¹⁵ recommandée dans la Charte (OMS, 1986) dont il est une

¹⁵ Les « milieux environnants » sont les lieux physiques et les espaces sociaux où nous menons notre existence. Du fait qu'il s'agit des « lieux » centraux dans nos vies, et parce qu'ils combinent les environnements sociaux et physiques, ils peuvent constituer d'importants axes de recherche pour les programmes de promotion de la santé. Les approches axées sur les milieux environnants qui sont largement adoptés dans la promotion de la santé au Canada et à l'étranger incluent les écoles saines, les lieux de travail sains, les hôpitaux sains, les prisons saines, les marchés sains, les communautés saines, et les villes

expression importante. Par conséquent, comme la promotion de la santé vue comme « le processus qui confère aux populations les moyens d'assurer un plus grand contrôle sur leur propre santé », la création d'une cité en meilleure santé (ou d'une communauté, terme préféré au Canada) est, elle aussi, vue comme un processus faisant intervenir nombre des approches stratégiques indiquées dans la Charte d'Ottawa (établir une politique publique saine, créer des milieux favorables, renforcer l'action communautaire, acquérir des aptitudes individuelles). Il s'agit clairement de la définition d'une cité saine élaborée dans le document de travail original préparé pour le projet des Villes-Santé du bureau de l'OMS pour l'Europe :

« Une ville saine est une ville où l'on crée et améliore constamment l'environnement physique et social et où l'on développe les ressources communautaires qui permettent aux gens de s'entraider dans la réalisation des fonctions de la vie et dans le développement maximal de leur potentiel ». (Hancock et Duhl, 1986)

Les « paramètres » d'une ville saine définis dans le document original du Bureau de l'OMS pour l'Europe illustrent bien l'éventail des questions qu'une initiative de communauté ou de ville saine pourrait avoir à traiter; celles-ci sont au moins aussi vastes que les « déterminants de la santé » définis plus d'une dizaine d'années plus tard par le Conseil consultatif sur la santé de la population (voir l'encadré 3).

Encadré 3 : La ville saine : définition et critères

Une ville en bonne santé est une ville où l'on crée et améliore constamment l'environnement physique et social et où l'on développe les ressources communautaires qui permettent aux gens de s'entraider dans la réalisation des fonctions de la vie et dans le développement maximal de leur potentiel.

Critères

1. Un environnement physique salubre, sans risques et de haute qualité (y compris au niveau du logement).
2. Un écosystème qui est stable dans le présent et pouvant être maintenu à long terme.
3. Une communauté forte, solidaire et qui n'exploite pas la population.
4. Un haut niveau de participation et de contrôle par la population pour tout ce qui concerne sa vie, sa santé et son bien-être.
5. La possibilité de satisfaire les besoins de base (alimentation, eau, abri, revenu, sécurité, emploi) de tous ses citoyens.
6. L'accès à une grande diversité d'expériences et de ressources, avec une possibilité d'élargir les contacts, les synergies et les communications.
7. Une économie locale diversifiée, dynamique et innovatrice.
8. L'encouragement du sentiment de lien avec le passé, c'est-à-dire avec le patrimoine culturel et biologique des citoyens, et avec d'autres groupes et individus.
9. Une structure de ville qui est compatible avec ce qui précède et qui le renforce.
10. Un niveau optimal de soins curatifs et de services de santé publique accessibles à tous.
11. Un bon état de santé (à la fois un état de santé positif et de faible morbidité).

(Source : Hancock, Trevor et Duhl, Leonard (1986) Healthy Cities : Promoting Health in the Urban Context. Copenhague, bureau de l'OMS pour l'Europe (également publié sous le titre de WHO Healthy Cities Paper, n° 1, publié par FADL, Copenhague, 1988)

Il importe également de noter que l'objectif final n'est pas la santé en soi, mais qu'il est lié au concept plus vaste de gens qui développent leurs potentialités de façon optimale, le concept de développement humain. De plus, conformément à la place qu'il occupe dans l'approche générale de la promotion de la santé, l'objectif central vise à donner aux êtres humains – individuellement et collectivement (par l'intermédiaire de leurs organisations communautaires et des structures politiques) – les moyens d'agir pour améliorer leur santé et leur niveau de développement humain. Pour cela, il faut adopter une démarche à long terme qui accorde une plus grande importance à la mobilisation et à l'habilitation politique aux niveaux local et communautaire sont plus importantes qu'aux projets à court terme (bien que ceux-ci puissent avoir leur importance dans le cadre du processus de mobilisation à long terme). Ce concept, comme celui de la promotion de la santé, a toujours posé problème à ceux qui se concentraient sur des résultats ciblés à court terme définis hors de la communauté (ce qui est souvent le cas de nombreux programmes gouvernementaux, comme nous le verrons plus loin). Sous de nombreux aspects, la

démarche de ville santé/communauté-santé est considérée, dans le meilleur des cas, comme une tentative de création d'un mouvement social communautaire plaidant en faveur de la santé, qui aide les communautés à définir elles-mêmes ce qui est important pour leur santé – quoi que ce soit – ainsi que la manière de l'améliorer.

Comme nous le verrons également plus loin, cette approche est compatible avec d'autres initiatives novatrices menées au Canada qui ont adopté une démarche similaire pour améliorer la condition des communautés canadiennes. Toutes posent les mêmes difficultés à la démarche d'action communautaire gouvernementale habituelle, et elles sont toutes victimes du même manque d'intérêt, qu'il convient d'examiner, parce qu'ensemble elles indiquent la voie à suivre pour l'action communautaire visant la santé de la population et le développement humain.

3.1 Communautés saines au Canada

Le Canada gère un mouvement de communautés saines depuis plus de 20 ans (nous préférons utiliser le terme « communauté » au Canada - ou ville et village au Québec – pour pouvoir inclure les petites communautés qui ne se considèrent pas comme des « villes » ainsi que les communautés qui se définissent comme telles ou les quartiers au sein des villes). Il existe trois initiatives largement ou entièrement financées au niveau provincial. Il n'y a pas d'initiative nationale; le financement de l'initiative des communautés saines du Canada qui a été établie en 1989 a fait l'objet de compressions durant la récession de 1991-1992.

- Au Québec, le Réseau québécois de Villes et Villages en santé (RQVVS) a été établi en 1990, et il est étroitement affilié à l'Institut National de Santé Publique du Québec (INSPQ) dans lequel il est situé, et aux municipalités du Québec, qui composent ses membres et la majorité de son conseil d'administration. Sa mission est :

« de promouvoir et de soutenir, à travers tout le Québec, le développement durable de milieux de vie sains. Il mise, pour ce faire, sur les échanges et le partage entre les municipalités, sur l'engagement des décideurs municipaux en faveur de la qualité de vie et sur leur capacité à mobiliser leurs partenaires et les citoyennes et citoyens dans l'action concrète ». (www.rqvvs.qc.ca/reseau/mission.asp)

Il comprend parmi ses membres 179 municipalités locales ou régionales (l'une d'elles étant une communauté de Premières nations) représentant plus de 50 pour cent de la population du Québec. En plus de ces membres officiels, un service de santé publique régional a la possibilité de travailler avec une municipalité dans le cadre d'une stratégie de communauté-santé, sans que cette municipalité soit tenue de joindre le RQVVS, de sorte que sa portée ne se limite pas à ces membres officiels; en fait, on estime que le RQVVS a travaillé avec 350 à 400 communautés ces cinq dernières années (communication personnelle de Louis Poirier, directeur, mars 2009).

Le budget de 2008-2009 pour le RQVVS s'élève à près de 500 000 \$, montant qui lui vient principalement du gouvernement du Québec, par l'intermédiaire de l'INSPQ.

- La Coalition des communautés en santé de l'Ontario (CCSO) est un organisme enregistré, constitué en personne morale, qui a pour mission de *travailler avec les diverses communautés de l'Ontario afin d'améliorer leur bien-être social, économique et environnemental*. Établie en 1992 et largement financée par le gouvernement, elle œuvre pour soutenir les groupes, coalitions et réseaux régionaux et locaux qui se consacrent aux initiatives communautés-santé en Ontario mais, par comparaison avec le RQVVS, elle est moins axée sur les gouvernements municipaux. La CCSO soutient les collaborations multisectorielles pour renforcer les économies locales, aborder les questions sociales et améliorer l'environnement, tout cela dans l'objectif ultime d'améliorer la santé de la communauté et de ses membres. (www.ohcc-ccso.ca/fr)

En septembre 2008, le CCSO comptait 376 membres répartis dans 143 secteurs, y compris 80 « membres communautaires » de tout l'Ontario (un membre communautaire est « une coalition d'organismes représentant au moins trois secteurs communautaires, a adopté l'approche de communauté en santé et travaille en matière d'amélioration du bien-être social, économique et environnemental de leur collectivité »), 15 organismes provinciaux couvrant le spectre social, environnemental, économique et politique, et 281 membres de réseaux, y compris quatre organismes d'autres provinces. Ces cinq dernières années, on estime que le CCSO a fourni des services à environ 350 groupes (communication personnelle de Lorna Heidenheim, directrice exécutive, mars 2009)

Le budget de 2008-2009 du CCSO s'élève à environ 720 000 \$, près de la moitié lui est fournie par le ministère de la Promotion de la santé de l'Ontario et 250 000 \$ par l'Agence de la santé publique du Canada et la Fondation Trillium chacune.

- L'initiative des communautés saines de la Colombie-Britannique [BC Healthy Communities initiative (BCHC)] a été établie au début des années 1990, mais son financement lui a été retiré peu de temps après. Elle a refait surface en 2005 grâce au financement du ministère de la Santé de la C.-B. par l'intermédiaire d'ActNow BC. Elle a pour vision que *toutes les communautés de la C.-B. créent et améliorent constamment les biens sociaux, environnementaux et économiques qui favorisent la santé, le bien-être, et la capacité de réaliser leur plein potentiel* et pour mission de *promouvoir l'approche de communauté-santé, en offrant une plate-forme commune pour le dialogue, la collaboration, l'apprentissage et l'action*.

BCHC soutient les communautés et les groupes communautaires qui adoptent une approche holistique et intégrée pour améliorer la santé, le bien-être et le développement sain dans leurs communautés au moyen de facilitation, d'ateliers, de trousseaux d'outils et de petites subventions de démarrage. La plupart des activités qu'elle mène actuellement porte sur les processus de mobilisation communautaire et de renforcement des capacités, notamment des forums et des ateliers, ou de petites interventions visant à promouvoir

l'activité physique, une alimentation plus saine ou l'embellissement paysager. Voir www.bchealthycommunities.ca

On estime que BCHC a travaillé avec plus de 400 organisations différentes dans 300 communautés de la C.-B. depuis son rétablissement. Son budget en 2008-2009 s'élevait à un peu plus de 550 000 \$, montant qui lui venait du ministère pour la Vie saine et le Sport de la Colombie-Britannique plus un autre montant estimé à 50 000 \$ en contributions en nature lui est venu de l'Union of BC Municipalities (UBCM) dans lequel il est situé.

Comme on peut le voir, ces trois réseaux provinciaux ont adopté une approche générale qui relie les facteurs économiques, sociaux et environnementaux et ils facilitent et soutiennent tous l'action axée sur la collaboration au sein des communautés. L'initiative du Québec accorde une grande importance aux gouvernements municipaux avec lesquels la province a établi des liens, alors que celle de l'Ontario est plutôt axée sur les réseaux et les organisations communautaires; tirant les enseignements de l'expérience de ses deux partenaires, l'initiative de la C.-B., fait les deux, en étant située à l'UBCM et en accordant la priorité au renforcement des capacités communautaires. Ces trois initiatives disposent de budgets à peu près similaires et réussissent à atteindre et à soutenir un grand nombre de communautés et à travailler avec elles avec des budgets vraiment très limités.

4. Mobilisation communautaire et renforcement des capacités

Un examen antérieur du projet Villes-Santé du bureau de l'OMS pour l'Europe (OMS, 1992) indique que les principaux éléments constitutifs d'une communauté saine sont :

- la mobilisation communautaire,
- les partenariats intersectoriels,
- l'engagement politique,
- la politique publique saine.

L'établissement de liens stratégiques entre ces quatre approches clés constitue ce que l'on pourrait décrire comme une stratégie locale visant l'amélioration de la santé de la population et du niveau de développement humain. Ensemble, elles développent et renforcent ou, pour être plus précis, elles s'appuient sur la capacité communautaire ou les actifs déjà présents dans chaque communauté. Ces dix dernières années, le développement communautaire reposant sur les actifs a de plus en plus remplacé la démarche par problème traditionnelle fondée sur les besoins pour aborder certains déterminants de la santé. Nous allons voir chacun d'eux.

4.1 Mobilisation communautaire

Selon le Tamarack Institute, le processus d'engagement citoyen comporte les cinq niveaux progressifs suivants :

1. **Passivité** – Les résidents et organismes locaux sont informés des problèmes par des organismes externes.
2. **Réaction** – Les résidents et organismes locaux fournissent leurs points de vue concernant les priorités et l'utilisation des ressources des organisations externes

3. **Participation** – Les résidents et organismes locaux influent sur les priorités et les organisations externes.
4. **Habilitation** - Les résidents et organismes locaux participent à la planification et à l'action avec les organisations externes.
5. **Leadership** – Les résidents et organismes locaux lancent et mènent l'action sur les problèmes avec le soutien des organisations externes.

Ce processus, qui rappelle la fameuse échelle de participation citoyenne de Sherry Arnstein¹⁶, pose de plus en plus de défis aux structures de pouvoir existantes à mesure que l'on progresse dans l'échelle; toutefois, bien que certains puissent le trouver pénible et exigeant, il est habilitant et libérateur pour la communauté et ses membres. En outre, tout porte à croire que l'habilitation des individus, qui entretient habituellement un lien réciproque et renforçant avec l'habilitation des communautés¹⁷ a, en soi, des effets positifs sur la santé de ceux qui sont habilités.

En fait, un tel processus d'habilitation est l'essence même de la promotion de la santé -- le « processus qui confère aux populations les moyens d'assurer un plus grand contrôle sur leur propre santé, et d'améliorer celle-ci ». Il est absolument essentiel pour le processus de création de communautés plus saines. Bien entendu, cela nous indique ce qui doit être fait, mais pas la manière de le faire; nous verrons cela plus loin, lorsque nous analyserons le travail du Tamarack Institute et son programme des collectivités dynamiques et autres initiatives similaires.

Nous nous contenterons de dire qu'il s'agit d'un processus de mobilisation communautaire long et lent qui exige de procéder par petites étapes sur lesquelles prendre appui, ce qui permettra d'acquérir une confiance et expérience croissantes. Comme pratiquement tout ce qui vise à améliorer les communautés et les rendre plus saines, il faut du temps, et il est indispensable d'élaborer des solutions locales aux conditions locales, et de ne pas imposer un modèle standard. (Cela ne veut pas dire que l'on ne peut pas tirer des enseignements des autres, ni trouver des principes à appliquer, parce qu'il y en a. Mais le modèle est le processus, non les modalités précises d'un programme.)

4.2 Partenariats intersectoriels

Il s'agit d'un domaine où notre terminologie a provoqué, et continue de provoquer une certaine confusion. Il est utile de considérer trois différents éléments de l'action intersectorielle (Hancock, 2008) :

- Action interservices/interministérielle/interorganisationnelle (Figure 3a)

Action menée au sein d'une organisation fonctionnant à n'importe quel niveau, local, mondial (public, privé, ONG), pour relier et coordonner les activités. Par exemple, un bureau de ville saine (comme à Toronto) ou un comité interservices dans un gouvernement municipal, un comité du Cabinet

¹⁶ Manipulation, Thérapie, Information, Consultation, Conciliation, Partenariat, Délégation de pouvoir, Contrôle citoyen

¹⁷ Il ne faut jamais oublier que dans les communautés malsaines, lorsque la communauté utilise son habilitation pour exploiter les membres les plus faibles et les plus défavorisés, ou d'autres communautés à proximité ou éloignées, cette habilitation peut nuire à la santé de quelques autres, sinon de plusieurs.

et un programme comme Enfants en santé Manitoba, ou un Comité directeur sur la santé en milieu de travail dans une corporation. En termes gouvernementaux, on appelle souvent cette approche pangouvernementale.

- Action intersectorielle (Figure 3b)

Action menée avec des partenaires de nombreux secteurs (public, privé, sans but lucratif, confessionnel, universitaire, professionnel, etc.), fonctionnant à n'importe quel niveau, du niveau local au niveau mondial. Citons, par exemple, une coalition communautaire en santé reposant sur une large assise, ou BC Healthy Living Alliance, qui inclut des NGO œuvrant dans le domaine de la santé, les associations professionnelles de la santé, l'Union of BC Municipalities, la BC Recreation and Parks Association, les autorités sanitaires de la C.-B. et (d'office) le ministre de la Santé et le bureau régional de l'ASPC, entre autres; toutefois, elle ne comprend pas encore le secteur privé.

- Intégration verticale (Figure 3c)

Action à plusieurs niveaux. Elle peut parfois aller du niveau local au niveau mondial, mais, plus couramment, elle comprend seulement quelques niveaux. L'Accord de Vancouver entre les gouvernements fédéral, provincial et municipal, ou les coalitions internationales d'ONG axées sur des questions comme l'allaitement au sein ou le contrôle du tabagisme en sont des exemples.

Figure 3a : Action interservices/interministérielle/ interorganisationnelle

	Gouvernement	ONG et communauté	Milieu universitaire	Secteur privé
Local	↓	↓	↓	↓
Régional	↓	↓	↓	↓
État	↓	↓	↓	↓
National	↓	↓	↓	↓
International	↓	↓	↓	↓

Figure 3b : Action intersectorielle



	Gouvernement	ONG et communauté	Milieu universitaire	Secteur privé
Local				
Régional				
État				
National				
International				

Figure 3c : Intégration verticale

	Gouvernement	ONG et communauté	Milieu universitaire	Secteur privé
Local				
Régional				
État				
National				
International				

Ces trois formes d'action intersectorielle doivent être opérantes pour qu'une approche fondée sur le renforcement des capacités communautaires ou la communauté saine soit efficace. Il faut d'abord que le gouvernement municipal s'engage à réunir les principaux services pour pouvoir élaborer des approches communes aux questions transversales. Cela doit ensuite être appuyé (ce qui est rarement le cas) aux niveaux provincial et fédéral par des processus ou structures comparables, afin que les actions de ces paliers supérieurs de gouvernement puissent favoriser une approche intégrée au niveau local.

Deuxièmement, le travail qui consiste à créer une communauté plus saine (ou meilleure) doit transcender la sphère gouvernementale; il est indispensable que l'approche mobilise toute la société. Il est évident que, non seulement les organisations doivent y participer, mais également chaque citoyen, et celle-ci est clairement liée aux stratégies de participation communautaire indiquées plus haut. De nombreuses communautés ont trouvé des moyens différents de réunir leurs intervenants; un moyen efficace pour trouver un but commun et mener une action commune, souvent sur plusieurs années, a été la création d'une vision commune. La ville de Rouyn-Noranda au Québec, par exemple, première communauté d'Amérique du Nord à se déclarer officiellement communauté en bonne santé (en 1987) a élaboré avec un grand nombre de ses jeunes une vision commune qui a continué d'éclairer la voie pendant de nombreuses années. De même, l'initiative de communauté saine dans le Township de Woolwich dans la région de Waterloo a été guidée pendant une vingtaine d'années par une vision communautaire élaborée à la fin des années 1980.

Troisièmement, il faut, non seulement que l'action locale soit soutenue par les gouvernements fédéral et provinciaux, mais aussi mettre en place un mécanisme qui permette aux trois ordres de gouvernement de devenir des partenaires – des partenaires voués à répondre aux besoins locaux, et non des partenaires dans la mise en œuvre d'objectifs prioritaires nationaux ou provinciaux orientés sur les questions locales.

4.3 Engagement politique

Bien que la création d'une communauté saine soit une tâche trop vaste pour qu'un gouvernement local puisse l'entreprendre à lui seul, celui-ci joue un rôle fondamental dans ce processus. Un engagement politique de haut niveau (des maires et conseillers) a été l'élément central du projet des Villes-Santé de l'OMS, et au Québec, de l'initiative Villes et Villages en santé.

Il est indispensable d'avoir parallèlement un différent type d'engagement politique de la part des dirigeants politiques des gouvernements fédéral et provinciaux; ceux-ci doivent reconnaître le rôle crucial du gouvernement local dans la création des conditions favorables à la santé et au développement humain, et s'engager à renforcer les pouvoirs et les ressources des gouvernements municipaux, comme nous le verrons plus loin.

4.4 Politique publique saine

« Politique publique saine » désigne l'élaboration d'une politique publique dans des secteurs non liés à la santé visant explicitement à améliorer la santé de la population. Ce concept s'est développé en même temps que le concept de ville ou de communauté saine (les deux ayant émergé dans la foulée de la conférence « Beyond Health Care » tenue à Toronto en 1984). On pourrait donc demander à n'importe quel ordre de gouvernement ce qui constituerait une politique « plus saine », que ce soit dans le transport ou le logement, le développement urbain ou les parcs, la gestion des déchets ou l'approvisionnement énergétique, l'agriculture ou l'éducation, l'économie ou toute autre politique non liée à la santé.

Il a été noté au début du développement du mouvement des villes en santé que c'était au niveau local que :

« [...] la pratique d'une politique publique saine se développe le plus rapidement là où ses effets sont les plus visibles. Il y a deux raisons évidentes à cela : bon nombre des problèmes liés aux facteurs environnementaux ou aux services sont plus visibles au niveau local. Tout comme le sont les changements nécessaires. Les politiciens à ce niveau ont des rapports plus étroits avec leurs électeurs et ils répondent de façon plus claire à leurs préoccupations. Les structures gouvernementales, même dans les grandes villes, interagissent plus facilement les unes avec les autres et trouvent des moyens de coordonner leur planification et leurs actions plus rapidement qu'au niveau national ». (Kickbusch, Draper et O'Neill, 1990)

Certaines caractéristiques peuvent rendre à la fois plus facile et plus difficile d'appliquer une politique publique saine au niveau local. Celles qui peuvent la rendre plus facile à appliquer au niveau local sont les suivantes :

- un certain degré « d'intimité locale » entre les principaux intervenants dans les petits réseaux sociaux et une communauté à une échelle un peu plus humaine;
- les décideurs (politiciens et personnel) vivent à proximité de leur lieu de travail et les décisions qu'ils prennent les touchent, touchent leurs amis, leurs voisins et leur famille;
- une organisation bureaucratique plus petite peut fournir des réponses plus rapidement et faciliter la rétroaction;
- des liens plus étroits entre la communauté et les décideurs;
- la possibilité de relier directement la défense des intérêts communautaires et l'action communautaire au changement d'orientation et aux décideurs.

D'autre part, les caractéristiques qui peuvent rendre plus difficile de suivre une politique publique saine au niveau local sont, entre autres :

- la possibilité qu'un nombre de grands enjeux, notamment économiques, soient déterminés au niveau national ou même international;
- la possibilité que le gouvernement local n'ait pas le pouvoir de modifier la politique ou que cela ne relève pas de sa compétence;
- la possibilité que le gouvernement central s'oppose aux initiatives et à l'autonomie locales;
- la possibilité qu'en décentralisant le gouvernement central se décharge sur les gouvernements locaux du fardeau ou de la responsabilité de la politique, mais ne leur donne pas le pouvoir ni les ressources nécessaires pour la mettre en œuvre;
- la possibilité que les politiciens locaux prétendent ne pas avoir le pouvoir d'agir, rejetant ainsi le blâme sur des instances supérieures;
- la possibilité que les administrations locales (notamment les plus petites) n'aient pas les ressources et l'expertise nécessaires. (Hancock, 1990)

On pourrait ajouter à cette liste le défi que pose la nécessité d'adopter une approche holistique à l'égard des déterminants de la santé et de ne pas cibler des problèmes individuels. Malheureusement, nos gouvernements, de tous les ordres, ne sont pas structurés pour adopter une approche holistique et nous manquons de gens possédant l'expertise nécessaire pour adopter une approche holistique.

Ce dernier point mérite d'être approfondi. Au Canada, nous avons essentiellement un système de gouvernement local qui date du XIX^e siècle, littéralement et métaphoriquement. L'origine des services de santé publique, de travaux publics, des parcs, de la planification et des autres services municipaux, remonte au XIX^e siècle. Ces services sont établis sur des modèles de secteurs distincts du XIX^e siècle, que l'on qualifie aujourd'hui de « cloisonnés ». Malheureusement, la plupart des problèmes, sinon tous, auxquels nous sommes confrontés au XIX^e siècle, touchent ces structures du XIX^e siècle. Comme ces anciens mécanismes ne fonctionnent plus pour nous, la première réaction a été de créer de nombreux organismes, comités, commissions d'étude et groupes de travail à vocation spécifique. Cette prolifération témoigne du mauvais fonctionnement du mécanisme et des structures actuelles et indique que nous devons donc créer tous ces organismes à vocation spécifique. Toutefois, il ne peut s'agir que d'une réponse temporaire. Tôt ou tard, étant donné que la structure actuelle ne peut répondre adéquatement aux défis qui se posent à nous au XXI^e siècle, nous devons créer de nouveaux processus et structures de gouvernance.

4.5 Développement communautaire reposant sur les actifs

Au milieu des années 1970, John McKnight, chercheur et intervenant en matière de développement communautaire aux États-Unis, a lancé l'idée qu'il fallait s'appuyer sur les dimensions positives d'une communauté pour mettre en œuvre le changement, au lieu de se concentrer exclusivement sur les problèmes de cette communauté, qu'il fallait se focaliser sur le verre à moitié plein plutôt que sur le verre à moitié vide, comme il le disait fréquemment, pour reconnaître les forces et les capacités des membres, des organisations, des institutions et des actifs d'une communauté.

Les importants travaux de McKnight, résumés ultérieurement dans « Building Communities from the Inside Out » (Kretzmann et McKnight, 1995), ont abouti au développement du concept de « développement communautaire reposant sur les actifs ». Kretzmann et McKnight ont fait remarquer que l'approche traditionnelle adoptée pour trouver des solutions au sans-abrisme, à la pauvreté, au chômage, à la criminalité et à la violence, a toujours été exprimée en termes négatifs du genre « quartiers nécessiteux, problématiques et déficitaires peuplés de gens nécessiteux, problématiques et déficitaires ». Il en a résulté un système fondé sur les besoins dans lequel les experts et les fournisseurs de service extérieurs – services gouvernementaux, organismes sans but lucratif, chercheurs universitaires et autres fournisseurs de services sociaux – viennent répondre aux besoins à l'aide de services et de programmes particuliers. Kretzmann et McKnight ont fait remarquer que cette approche finissait par désactiver les membres de la communauté qui devenaient des clients passifs des services. Cette approche a favorisé la création d'une mentalité de victime, encouragé un sentiment d'impuissance et de désespoir acquis chez les résidents qui ont commencé à se juger incapables de prendre en main leur propre vie ou de changer leur communauté pour l'améliorer.

Selon les auteurs, cette approche fondée sur les besoins ou sur les problèmes a également d'autres conséquences négatives :

- la fragmentation des services, chacun d'eux visant à s'attaquer à un problème particulier, au lieu d'adopter une approche holistique;
- l'orientation du financement vers les fournisseurs de services et non vers les membres de la communauté;
- l'affaiblissement du leadership communautaire et des relations communautaires. Les relations les plus importantes sont celles qui s'établissent entre l'expert de l'extérieur (travailleur social, intervenant en santé, bailleur de fonds) et le client, plutôt qu'entre les résidents de la communauté;
- un renforcement du cycle de la dépendance – pour que le financement soit renouvelé, par exemple, il faut que les problèmes se poursuivent et soient pires que dans les autres quartiers. L'incitation véritable à résoudre les problèmes est inexistante.

Plutôt que de se concentrer sur les besoins et les problèmes, John McKnight a préconisé une autre façon d'élaborer les politiques et les activités; elle consiste à s'appuyer sur les capacités, les compétences et les actifs des personnes à faible revenu et de leurs quartiers. En mettant en valeur les capacités, les communautés peuvent prendre en main leurs propres problèmes. Kretzmann et McKnight ont fait remarquer que l'on ne peut assurer le développement de la communauté que si les résidents locaux se sont mobilisés pour s'investir et investir leurs ressources dans les efforts d'amélioration. On ne bâtit jamais une communauté de l'extérieur ou de façon descendante, mais de l'intérieur et à partir de la base. Une aide extérieure est souvent requise, mais elle ne devrait servir qu'à aider à renforcer les actifs communautaires. Les auteurs font remarquer que même le quartier le plus pauvre est un lieu où les individus et les organisations sont des ressources qu'il faut exploiter.

McKnight et Kretzmann ont depuis créé l'Asset-Based Community Development Institute à la Northwestern University de Chicago. Cet institut mène de nombreuses recherches et publie de nombreux ouvrages sur le développement communautaire, produit des ressources et des outils pratiques à l'intention des bâtisseurs de la communauté, et il offre de très nombreux ateliers sur le développement des quartiers, des actifs et des réseaux communautaires dans toute l'Amérique du Nord. (Voir www.sesp.northwestern.edu/abcd/)

Ces dix dernières années, le modèle de développement communautaire reposant sur les actifs a suscité de plus en plus d'engouement. En fait, les initiatives Inclusive Cities Canada et Collectivités dynamiques, décrites dans la prochaine section, utilisent toutes deux ce modèle pour mettre en œuvre le changement et inciter l'engagement. Les conseils de planification sociale, certains d'eux en existence depuis neuf décennies et fonctionnant souvent en fonction des besoins, font équipe avec l'initiative Inclusive Cities, et adoptent cette orientation plus positive.

Jim Diers, autre promoteur du développement communautaire reposant sur les actifs et auteur de *Neighbor Power: Building Community the Seattle Way* (Diers, 2004), œuvre dans le développement communautaire à Seattle depuis plus d'une trentaine d'années. Diers est aujourd'hui la principale autorité en matière de développement communautaire à la faculté de l'Asset-Based Community Development Institute et à l'University of Washington. Son modèle de démocratie participative a connu un tel succès qu'il a été adopté dans d'autres centres. Diers a récemment signé un document de travail pour la Canada West Foundation intitulé *From the Ground Up: Community's Role in Addressing Street*

Encadré 4 : Des fonds de contrepartie donnent un nouveau visage à Seattle

Il y a vingt ans, Seattle lançait un programme innovateur visant à promouvoir l'innovation dans les quartiers et la mobilisation communautaire.

Établi par Jim Diers en 1988, le Neighborhood Matching Fund a depuis financé plus de 3 000 projets communautaires et accordé 42 millions de dollars en subventions communautaires. Les quartiers ont complété cette contribution en fournissant 65 millions de dollars en dons en espèces, en services en nature et en heures de bénévoles. En 1991, la Fondation Ford et la Kennedy School of Government de l'Université Harvard ont qualifié ce Fonds de l'une des 10 initiatives locales les plus innovatrices des États-Unis.

Ces vingt dernières années, le programme a fourni des montants allant de 100 \$ à 300 000 \$ pour des projets de quartiers qui incluaient tout, embellissement des rues et des parcs, jardins communautaires, rénovation de bâtiments, et même des projets d'histoire orale. La contribution de la ville s'élève aujourd'hui à 2,5 millions par an. Certains des projets les plus notables sont :

Le Fremont Troll – L'espace au-dessous du pont Aurora de Seattle était le paradis des trafiquants de drogues, des sans-abri et d'autres activités indésirables. En 1991, grâce à l'argent du Fonds, les artistes de la communauté avoisinante de Fremont ont construit un énorme troll qui serre dans sa main une vraie coccinelle Volkswagen. Cette sculpture est devenue une attraction touristique et elle est même utilisée dans des événements comme « Shakespeare on the Troll ».

- Une piste populaire pour vélos de montagne a été construite au-dessous d'une autoroute.
- Une murale qui s'étend sur plus de 2 km a été peinte le long de la cinquième avenue, route très achalandée fréquentée par les navetteurs.
- Une aire de jeux pour enfants a été construite sur le thème du saumon dans un parc où trône un énorme toboggan en forme de saumon.

Les projets financés grâce aux fonds de contrepartie permettent habituellement de réunir des centaines de gens dans la communauté, des travailleurs de la construction, des équipes de scouts, des citoyens âgés, des artistes et militants. Ce programme a depuis été adopté par des centaines de communautés du monde entier.

*Level Social Issues (2008)*¹⁸. Dans ce résumé de son ouvrage plus vaste, il indique que la prévention, grâce à la création de communautés fortes et inclusives, est la seule solution à long terme aux problèmes liés à la toxicomanie, la prostitution, au sans-abrisme et à la pauvreté. Toutefois, pour cela, il faut que les citoyens se mobilisent. Diers fait remarquer que les gens ne se mobiliseront que s'ils ont du plaisir à fournir cet effort, si celui-ci donne des résultats, s'il utilise ce qu'ils ont à offrir et s'il se déploie là où ils vivent, dans leur réseau, leur îlot urbain, et qu'il touche un sujet qui les passionne.

Le rôle du gouvernement et d'autres organismes est d'aider à renforcer la capacité communautaire de manière à financer et encourager les initiatives communautaires qui sont dirigées par la communauté et qui s'appuient sur ses propres forces. Voici deux exemples d'initiatives menées durant la période pendant laquelle Diers était directeur du *Department of Neighborhoods* à Seattle :

- un Fonds de financement de contrepartie qui a permis de doubler l'investissement de 45 millions de dollars de la municipalité et d'engager des dizaines de milliers de bénévoles pour exécuter plus de 3 000 projets communautaires depuis 1989 (voir l'encadré 4);
- un Programme de planification à l'échelle de quartiers a permis aux quartiers d'engager leurs propres consultants; 30 000 personnes ont participé à l'élaboration de 37 plans de quartier entre 1996 et 1999. Par la suite, les citoyens ont obtenu par vote 470 millions de dollars en nouvelles taxes pour aider à mettre en œuvre ces plans.

Dans son document de travail de 2008, Dier documentait de nombreux moyens novateurs ayant permis à des quartiers d'Amérique du Nord de réduire, d'éliminer ou de prévenir certains grands problèmes sociaux qui nuisaient à la santé des individus et au bien-être de la communauté : l'établissement de réseaux et de relations, la promotion de l'inclusivité des quartiers, la participation des personnes « étiquetées » (toxicomanes, prostitués, sans-abri) à la solution – essentiellement en amenant les gens à travailler ensemble pour le bien commun.

Toutefois, le fait que divers ordres de gouvernement et organismes communautaires continuent de financer le modèle fondé sur les besoins ou sur des problèmes spécifiques constitue un important obstacle au développement communautaire reposant sur les actifs. En fait, ce problème concernant le financement de modèles pour le développement communautaire a été constamment soulevé au cours des entrevues avec les intervenants clés.

Commentaires d'intervenants clés

« La façon dont les choses sont actuellement financées empêche d'adopter une approche reposant sur les actifs. Elle empêche de prendre du temps pour réfléchir et établir des relations et comprendre le dialogue nécessaire pour avancer. Les bailleurs de fonds souhaitent financer des services directement offerts dans la communauté [...] Le renforcement des capacités communautaires n'est pas un service direct et ils ne veulent donc pas le financer. Nous avons des corporations de développement économique, pourquoi n'avons-nous pas de corporation de développement social ».

¹⁸ www.cwf.ca/V2/files/CCI%20Diers.pdf

Le développement fondé sur les actifs est peut-être le principal mécanisme qui permette aux communautés de créer les cinq formes de capital, de renforcer la résilience personnelle et communautaire et d'améliorer le niveau de la santé de la population et du développement humain. Dès le début il était un aspect important de l'approche fondée sur la communauté en bonne santé au Canada, et il est au cœur de plusieurs autres initiatives créatives menées au Canada pour maximiser le développement humain et le bien-être de la communauté et de ses citoyens. À ce titre, il doit devenir un élément central du travail des gouvernements fédéral et provinciaux avec les communautés et dans les communautés.

Toutefois, comme nous l'indiquerons à la prochaine section, tout processus de développement communautaire complet à long terme qui repose sur les actifs n'apparaît pas de manière fortuite. Il exige un engagement financier à long terme et d'autres moyens qui permettent d'appuyer tant le processus communautaire que l'infrastructure de soutien communautaire nécessaires au niveau communautaire.

5. Nouveaux modèles de gouvernance communautaire pour la santé et le développement communautaire

Au Canada, en plus des trois initiatives provinciales de communautés saines, diverses organisations cherchent à aborder certains déterminants de la santé et du développement humain par le renforcement des capacités communautaires et la mobilisation de la communauté, pour s'attaquer essentiellement à la question de la pauvreté, de l'inclusion et des communautés actives. Nous décrivons dans cette section plusieurs grandes initiatives nationales qui ont été menées dans de grandes villes du pays ou dans une petite communauté autochtone. Nous analyserons ensuite le nouveau concept de « gouvernance urbaine saine » et l'infrastructure nécessaire pour la gouvernance communautaire.

5.1 Le Tamarack Institute et les Collectivités dynamiques

Le Tamarack Institute se décrit lui-même comme étant un institut qui prône la mobilisation communautaire. Fondé en 2002 par Alan Broadbent de la Maytree Foundation et Paul Born, l'Institut a pour mission d'aider les citoyens de différents secteurs de la communauté à travailler ensemble pour apprendre à se charger des questions qui touchent toute leur communauté. En assimilant cet effort à une corvée pour la construction d'une grange amish traditionnelle, Tamarack fait valoir qu'en travaillant ensemble, les communautés peuvent aborder leurs problèmes locaux et leur trouver des solutions. Un sentiment de bien-être découle du degré de familiarité et de confiance atteint grâce au contact, à la responsabilité partagée et au soutien.

Selon l'Institut, lorsque le niveau de participation citoyenne est élevé, la qualité de la vie communautaire s'améliore en général. Dans les communautés où les citoyens collaborent étroitement les uns avec les autres, on constate de plus hauts niveaux de scolarité, un meilleur développement des enfants, des quartiers plus sûrs, une plus grande prospérité économique, et des citoyens en meilleure santé physique et mentale. Toutefois, il doit y avoir au préalable une volonté communautaire – un sentiment clair que la communauté souhaite s'occuper de problèmes tels que celui de la pauvreté ou de la santé.

Tamarack fait remarquer que les citoyens peuvent exercer une grande influence et avoir des effets importants sur la vie de leurs communautés. À ce titre, il s'est positionné de façon à faciliter la mobilisation communautaire en offrant un ensemble de programmes et de services. Créée en 2002, l'initiative des Collectivités dynamiques est l'un des principaux programmes du Tamarack. Il s'agit d'un programme dirigé par la communauté qui vise à réduire la pauvreté au Canada en créant des partenariats entre des particuliers, des organisations, des entreprises et les gouvernements. Ce programme, appuyé par le Caledon Institute of Social Policy et la J.W. McConnell Family Foundation, comprend aujourd'hui 15 communautés canadiennes¹⁹. L'initiative Collectivités dynamiques met sciemment à l'essai des idées sur le renforcement communautaire, la réduction de la pauvreté, la collaboration et l'engagement, et génère un savoir fondé sur ce qui fonctionne le mieux dans la pratique.

Son travail est fondé sur cinq approches fondamentales :

- orienter l'objectif vers les efforts qui réduisent les causes de la pauvreté plutôt que vers les symptômes de la pauvreté;
- intégrer les initiatives locales visant la réduction de la pauvreté;
- inciter tous les secteurs de la communauté à collaborer à ces initiatives au niveau local;

Encadré 5 : Calgary poursuit l'objectif du salaire-subsistance dans le cadre des Collectivités dynamiques

Aux États-Unis, ces dix dernières années plus de 130 collectivités ont adopté des politiques sur le salaire-subsistance. Un salaire-subsistance est le montant de revenu dont un particulier ou une famille a besoin pour répondre à ses besoins de base, maintenir des conditions de vie convenables et sûres dans sa communauté, et épargner en vue de ses besoins et objectifs futurs. Dans le cadre de son initiative Collectivités dynamiques, une équipe d'action comptant plus de 20 partenaires met en œuvre une campagne de salaire-subsistance à Calgary.

Le salaire minimum en Alberta est 8,40 \$ de l'heure. En travaillant un nombre d'heures standard de 35 heures par semaine, 52 semaines par an, un individu sans personne à charge employé au salaire minimum gagnerait un salaire annuel net de seulement 14 287 \$ (en comprenant la paye de vacances). Ce revenu serait inférieur de 7 379 \$ au SFR fixé par Statistique Canada pour un individu résidant dans une grande ville (21 666 \$). L'équipe d'action pour le salaire-subsistance dans le cadre des Collectivités dynamiques a déterminé qu'une personne qui travaille à temps plein (35 heures par semaine, 52 semaines par an) doit gagner au moins 12 \$ de l'heure plus les avantages sociaux (ou 13,25 \$ de l'heure en remplacement des avantages sociaux) pour gagner un salaire-subsistance. La recherche montre que 65 000 (10,8 %) Calgariens employés de plus de 15 ans gagnent moins de 12 \$ de l'heure et que les femmes sont représentées de façon disproportionnée au sein de ces employés à bas salaire, 45 000 d'entre elles gagnant moins de 12 \$ de l'heure.

Le *Living Wage Leader Program* à Calgary (programme du salaire-subsistance) honore et récompense les employeurs qui paient à leurs employés un salaire-subsistance. En février 2009, la première entreprise à recevoir le prix était la Chambre de commerce de Calgary. De plus, le Conseil municipal de Calgary a demandé à l'administration municipale d'élaborer des propositions de politique relatives au salaire-subsistance à appliquer au personnel municipal et aux fournisseurs de services urbains et de présenter un plan de mise en œuvre pour 2009.

Sources

Fiche de renseignements sur le salaire-subsistance dans les Collectivités dynamiques à Calgary
<http://www.vibrantcalgary.com/media/VCC%20Living%20Wage%20Fact%20Sheet%20May%202008.pdf>

Vibrant Calgary Living Wage Program
 Site Web www.vibrantcalgary.com/livingwage

¹⁹ Abbotsford, Calgary, Cap Breton, Edmonton, Hamilton, Montréal, Niagara, Saint John, St. John's, Saskatoon, Surrey, Trois-Rivières, Victoria, région de Waterloo, Winnipeg

- définir les actifs communautaires et les utiliser dans les initiatives de lutte contre la pauvreté;
- une détermination à apprendre, changer et mettre en commun ce qui a été appris – tant des succès que des échecs.

Bien que les résultats des Collectivités dynamiques demeurent préliminaires, au cours d'une entrevue, Paul Born, leur fondateur, a fait remarquer que certaines communautés qui ont un gouvernement local et des citoyens mobilisés et qui ont pris leurs problèmes en main ont une énorme capacité de faire d'importantes transformations sociales. À titre d'exemple, dans le cadre des Collectivités dynamiques, les citoyens et le gouvernement de Calgary ont pu mettre en place un laissez-passer pour les transports en commun destiné aux citoyens à faible revenu qui coûte la moitié moins cher que le prix régulier. « Cela peut sembler peu de choses, mais en fait c'est beaucoup, parce qu'il s'agit d'un principe que nous n'avons pas réussi à exporter dans d'autres villes de ce pays, à savoir l'importance du transport comme bien public, élément fondamental pour l'économie et l'infrastructure de l'emploi. Autrement dit, si les gens ne peuvent pas se payer le transport en commun, ils ne pourront pas aller travailler chez McDonald's ».

D'autres actions menées dans le cadre des Communautés dynamiques ciblaient les enfants pauvres d'Hamilton, les familles monoparentales de Saint John au Nouveau-Brunswick et le logement abordable à Victoria.

5.2 Conseils de planification sociale et Inclusive Cities Canada

Dans de nombreuses villes du pays, il existe des conseils de planification sociale municipaux, de nombreux en existence depuis 80 ou 90 ans sous forme d'organisations communautaires, qui s'emploient à trouver des solutions aux problèmes urgents du sans-abrisme, de la pauvreté des enfants, de la sécurité alimentaire, du logement abordable et du soutien des immigrants. Nombre de ces organisations reçoivent des fonds de groupes tels que Centraide. Comme le Conseil de planification sociale d'Ottawa le note sur son site Web, il a pour mission de traiter les questions sociales, d'améliorer la qualité de vie à Ottawa et de servir de « ressource à guichet unique pour la recherche sociale indépendante, la planification communautaire et le soutien au développement communautaire pour les individus, les organismes et les réseaux qui opèrent un changement positif ».

Le Conseil canadien de développement social est un institut de recherche indépendant, à but non lucratif, en existence depuis 90 ans, axé sur la pauvreté, l'inclusion sociale, les personnes handicapées, la diversité culturelle, le bien-être des enfants, l'emploi et le logement; il relie tous les conseils de planification sociale au Canada. (www.ccsd.ca)

En 2003, une initiative axée sur la collaboration entre cinq conseils de planification sociale²⁰ et la Fédération canadienne des municipalités a abouti à Inclusive Cities Canada (ICC). Ils ont pris acte que l'inclusion sociale était considérée comme un déterminant fondamental de la santé. Le faible revenu, de mauvaises conditions de logement, l'insécurité alimentaire, sont des facteurs qui créent des sentiments d'exclusion sociale et, combinés au manque de participation aux décisions touchant les citoyens, créent un

²⁰ Burlington (comté d'Halton), Edmonton, Saint John, Toronto, Vancouver/North Vancouver

mauvais état de santé, des taux plus élevés de maladies chroniques et de morbidité prématurée. Chaque ville a créé un comité de citoyens pour documenter le degré d'inclusivité de sa ville en se fondant sur cinq dimensions de l'inclusion sociale :

- la reconnaissance institutionnelle de la diversité,
- les possibilités de développement humain,
- la qualité de l'engagement des citoyens,
- la cohésion des conditions de vie,
- le caractère adéquat des conditions de vie.

Inclusive Cities mène des recherches et incite le leadership local et la communauté à contribuer à façonner la politique publique et les pratiques institutionnelles. Son but est de créer une « alliance citoyenne horizontale » en matière d'inclusion sociale dans toutes les communautés urbaines du Canada. L'inclusion sociale consiste également à traiter des problèmes qui favorisent l'isolement comme la pauvreté, le sans-abrisme, le manque de soutien social, les questions touchant l'immigration et autres.

5.3 L'Accord de Vancouver

Ces dix dernières années, de nouveaux modèles de coopération entre les divers ordres de gouvernement sont apparus sous forme d'accords sur le développement urbain, le plus connu étant l'Accord de Vancouver. La nature de certaines questions communautaires est si complexe qu'elles exigent de nouvelles structures de gouvernance et de nouveaux partenariats multiréseaux.

Cela a été le cas du quartier Downtown Eastside (DTES) de Vancouver à la fin des années 1990. Une crise de santé publique sous la forme d'une épidémie de décès causés par des surdoses et d'une brusque augmentation de maladies sexuellement transmissibles, en particulier du VIH/sida, de la syphilis et de l'hépatite C, a frappé ce quartier historique qui abrite une communauté de personnes à faibles revenus. Les taux élevés de toxicomanie, de troubles mentaux, de criminalité, de chômage, de pauvreté et de sans-abrisme sévissent également dans la région. Le DTED, qui compte environ 16 000 résidents, a un taux de maladie qui correspond à celui des pays du tiers-monde.

En mars 2000, pour s'attaquer aux problèmes de sécurité, de santé publique, sociaux et économiques, les représentants des trois ordres de gouvernement, fédéral, provincial et municipal, ont signé un accord historique, la première phase du projet s'étendant jusqu'en 2005. À cette date, l'accord a été renouvelé pour une seconde phase allant jusqu'en 2010. Chaque ordre de gouvernement devait contribuer en ressources financières, en personnel et en services en nature. Pour la première phase, les gouvernements fédéral et provincial ont fourni 10 millions de dollars chacun ainsi que des ressources en personnel; la coordination a été assurée par les ministères et services existants. La municipalité de Vancouver a contribué aux coûts en matière de personnel, d'espace dans les bâtiments municipaux, et sous forme d'indemnisation des coûts de zonage et d'utilisation des locaux, d'incitatifs à la préservation du patrimoine et de financement pour les projets d'immobilisation comme la rénovation d'anciens bâtiments.

Avant l'Accord, les trois ordres de gouvernement étaient chargés de régler différents problèmes qu'ils abordaient séparément, de façon disparate, et les personnes tombaient entre les mailles du filet. Ils ne collaboraient pas entre eux et ne coordonnaient pas non plus les services. Grâce à cet accord, on a reconnu que la seule façon d'aborder les problèmes complexes entrecroisés du DTES et trouver des solutions passait par la coordination des services et de l'expertise, et par la collaboration avec les résidents, les groupes communautaires et le monde des affaires.

Cet accord a réuni un vaste éventail d'autres partenaires communautaires tels que la Vancouver Coastal Health Authority, des entreprises locales et des organismes communautaires, ainsi que des groupes sans but lucratif œuvrant dans le DTES. Des réunions sont maintenant tenues à différents niveaux avec divers représentants, allant des fonctionnaires élus aux groupes de travail formés de fonctionnaires de niveau intermédiaire ou supérieur, aux représentants communautaires. Le travail collectif de tous ces partenaires a les buts importants suivants, comme on peut le lire sur le site Web de l'Accord.

- **Coordination** - Accroître les efforts coordonnés des trois ordres de gouvernement et des organismes publics connexes afin d'obtenir les résultats prévus en matière de changement et d'intervention dans les communautés.
- **Innovation** - Inciter les organismes publics à faire preuve d'innovation et de créativité dans leur façon de travailler ensemble et en partenariat avec le secteur privé et celui des organismes sans but lucratif.
- **Changement de politique** - Déterminer les obstacles découlant des politiques des gouvernements et des organismes publics qui empêchent d'apporter des changements et d'intervenir efficacement, et supprimer ou atténuer ces obstacles.
- **Investissement** - Accroître les investissements publics et privés (ressources financières et humaines) afin d'obtenir les résultats prévus en matière de changement et d'intervention.
- **Surveillance et évaluation** – Déterminer les principaux indicateurs de référence permettant de suivre les progrès et d'évaluer les réalisations concrètes.

En vue d'atteindre ces objectifs, l'Accord de Vancouver axe ses efforts sur cinq stratégies :

- Faciliter la tenue de forums et la mise sur pied de groupes de travail;
- Mettre en œuvre les processus mixtes de planification des organismes publics;
- Soutenir l'apprentissage par des activités d'échange de renseignements, de recherche, d'évaluation et de suivi des progrès.
- Trouver des méthodes et des moyens efficaces d'évaluation des projets mixtes des organismes publics et formuler des recommandations visant à améliorer l'efficacité.

- Investir des fonds dans des projets d'organismes publics et mobiliser d'autres ressources financières et humaines en établissant des partenariats avec le secteur privé.

L'Accord de Vancouver visait les quatre principaux résultats suivants de ces activités coordonnées et mobilisations accrues en matière de temps, de ressources financières et d'expertises :

- De meilleurs résultats sur le plan de la santé, qui comprennent un plus grand choix de solutions et une plus grande capacité de répondre aux besoins des résidents;
- Renforcement de la sécurité et prévision des conséquences néfastes du crime;
- Amélioration du nombre, de la taille et de la diversité des entreprises locales et augmentation des possibilités d'emploi à l'intention des résidents;
- Amélioration et augmentation des options en matière de logement, dont la location abordable, les logements avec services de soutien et les logements de transition.

Au cours des cinq premières années, un nombre d'importants changements ont été effectués :

- **Amélioration de la santé des résidents :**

- Baisse importante des taux de décès dus à la consommation de drogues, d'alcool, aux suicides et aux infections à VIH/sida.
- Meilleur accès aux services de soins primaires grâce à l'ouverture de nouvelles cliniques de santé.
- Ouverture en 2003 du premier site d'injection supervisé en Amérique du Nord – projet fortement controversé qui a permis, d'après les études menées, de réduire les dommages créés par l'utilisation de drogues injectables et d'améliorer la participation au traitement.
- Création d'un plus grand nombre de lits de désintoxication, de ressources pour le traitement des toxicomanies et la désintoxication des jeunes, notamment la mise en œuvre d'un programme de traitement sur place au site d'injection supervisé et l'expansion des services de traitement à la méthadone.
- Service central d'aiguillage par téléphone pour l'accès aux services de désintoxication des jeunes et des adultes.

- **Réduction de la criminalité :** Le nombre d'infractions contre les biens a diminué de 14 % entre 2000 et 2005

- **Croissance du nombre d'entreprises et de possibilités d'emploi :**

- Le nombre de programmes de formation à l'emploi et de soutien à l'emploi à l'intention des chômeurs de la région a augmenté, y compris pour les personnes toxicomanes ou aux prises avec des maladies mentales.
- **Augmentation des options de logement :**
 - Réalisation de 53 projets de développement entre 2000 et 2005, y compris neuf immeubles de logements subventionnés, 12 ensembles résidentiels du marché, trois ensembles à vocation mixte avec des garderies, un espace commercial et de logement, et un nombre d'installations sanitaires. Une rénovation majeure est celle du bâtiment Woodward. (Voir l'encadré 6)
 - Rénovation et remise en état des hôtels à chambres individuelles, à commencer par le Silver and Avalon Hotel en 2005.
 - Création de 911 logements subventionnés supplémentaires en cinq ans et 259 lits ou unités d'habitation de plus pour les personnes âgées ou les personnes qui sont handicapées ou ont des problèmes de santé mentale.

En mars 2005, les trois ordres de gouvernement ont prolongé l'Accord de cinq ans. En juin 2005, l'Accord

Encadré 6 : Le bâtiment Woodward réaménagé agrémente le DTES d'un espace innovateur à usages multiples

Depuis 1903, le fameux bâtiment Woodward de Vancouver, avec son énorme W au néon, est une structure dominante du centre-ville est. Ce grand magasin a fermé ses portes en 1993, ce qui a largement contribué à l'exode des entreprises du DTES. Les dix années suivantes, de nombreux plans de redéveloppement n'ont pas abouti et la structure laissée vacante, qui se délabrait, occupée par les squatters, était devenue le symbole des problèmes complexes du DTES.

En 2001, le gouvernement provincial a acheté le bâtiment pour la somme de 22 millions de dollars et l'a revendu en 2003 à la municipalité pour la somme de 5 millions de dollars. Un processus de consultation de la communauté unique en son genre a alors eu lieu. Il en a résulté la première structure à usage mixte hautement diversifié de cette envergure sur un site du Canada (et peut-être du monde entier), qui constitue un élément essentiel pour la revitalisation du DTES.

Des 546 logements, 125 sont des logements sociaux d'une seule personne dotés d'équipements tels des montants muraux pour suspendre les bicyclettes. Les autres logements sont des logements commerciaux, qui rivalisent avec n'importe quelle copropriété du centre-ville de Vancouver et qui se sont vendus en l'espace de huit heures. On trouve également sur le site des détaillants populaires (London Drugs, Nesters Food Store), les bureaux de l'Ouest de l'Office national du film, et le nouveau centre d'arts contemporains de l'Université Simon Fraser, y compris cinq salles de spectacle. L'immeuble, qui inclut la restauration de la plus ancienne structure patrimoniale, abritera également un espace de bureau pour les organismes sans but lucratif de la communauté.

« Sa diversité est sans parallèle » a dit l'architecte Gregory Henriques, qui a qualifié cette entreprise « d'expérience sociale monumentale et passionnante ».

Les premiers locataires sont attendus en juin 2009. Lorsque le projet sera complètement terminé, le couronnement de l'aventure sera la remise en place de l'énorme néon en forme de W – remis à neuf et soigneusement entreposé ces années passées – pour qu'il puisse de nouveau dominer l'horizon et rendre honneur à cette structure historique.

Pour avoir plus d'information.

<http://vancouver.ca/bps/realestate/woodwards/>

de Vancouver a reçu l'un des huit prix décernés par les Nations Unies en matière de service public pour l'amélioration, la transparence, la reddition de comptes et la réponse aux besoins des citoyens dans les services publics.

S'appuyant sur la réussite de l'Accord de Vancouver, d'autres municipalités confrontées à d'importants problèmes de toxicomanie, de sans-abrisme et de pauvreté, notamment Victoria (C.-B.), ont amorcé des discussions, auxquelles ont participé les trois ordres de gouvernement, pour mettre en place un accord de développement urbain de ce type pour leur région.

Toutefois, à la suite de l'élection de janvier 2006, l'administration conservatrice minoritaire a succédé à l'administration libérale et, selon certaines sources, l'Accord de Vancouver a perdu son efficacité à tous égards. L'accord existe toujours sur le papier et il est toujours vanté comme un modèle de collaboration remarquable à plusieurs niveaux. Toutefois, depuis 2006, il n'y a pas eu de mises à jour sur ce qui était un site Web très dynamique. Il n'y a pas eu de communiqués de presse depuis le printemps 2006, ni de mises à jour sur les engagements financiers. Bien qu'il n'y ait pas d'indications officielles de nouveaux investissements, il semble que bien que le gouvernement provincial ait fourni un montant supplémentaire de 8,5 millions de dollars, il n'y ait pas eu d'autres fonds du gouvernement fédéral. De plus, en 2006, un nombre d'employés essentiels ont quitté le poste qu'ils occupaient dans le cadre de l'Accord de Vancouver pour aller ailleurs, notamment le premier directeur exécutif et le chef des relations avec les médias. Un important travail de revitalisation se poursuit dans le DTES avec le gouvernement provincial et l'administration municipale, les organismes locaux et les organismes sans but lucratif, mais il semble que la participation du gouvernement fédéral dans le cadre de l'Accord se soit affaiblie.

En même temps à Victoria, à la fin de 2006, les négociations visant à établir l'Accord de Victoria ont graduellement abouti à une impasse et l'initiative en est au point mort. Bien qu'il ait été déclaré officiellement que l'Accord était remis, de nombreux responsables clés, comme le gestionnaire de projet, sont partis occuper d'autres emplois.

Le succès initial et l'abandon subséquent apparent (mais pas officiel) de l'Accord de Vancouver illustre un obstacle clé de ces accords complexes à plusieurs niveaux : ils sont extrêmement vulnérables aux sautes de vent de la politique. Avec trois ordres de gouvernement, il y a trois fois plus de programmes politiques, trois fois plus de changements possibles de gouvernement, et trois fois plus de travail pouvant être retardé ou interrompu.

Les questions relatives aux déterminants de la santé sont des questions sociétales à long terme qui doivent transcender la partisanerie politique et durer au-delà des mandats politiques de quatre ans. Les résultats ne sont souvent pas visibles avant des années, et il doit donc y avoir un moyen stable et cohérent de rester focalisé sur les initiatives prometteuses et de poursuivre les efforts. Comme nous le montrons dans la section suivante, les obstacles auxquels se heurte ce type de travail abondent.

5.4 Oujé-Bougoumou – Une communauté autochtone inspirante

Oujé-Bougoumou est une communauté crie d'environ 650 personnes située au nord du Québec. L'histoire étonnante de sa transformation de communauté marginalisée et exclue

dans les années 1970 en une communauté qui s'est prise en main et qui est aujourd'hui un modèle de développement humain durable est tout à fait inspirante. La communauté personnifie la fameuse remarque de Margaret Mead – « Ne doutez jamais qu'un petit groupe de citoyens sérieux et résolu ne peut changer le monde; c'est en effet la seule chose qui l'ait jamais fait changer ». La population d'Oujé-Bougoumou a non seulement immensément changé le monde dans lequel elle vit, elle en a inspiré d'autres qui ont pu voir ce qu'il était possible de faire dans leurs propres communautés, et de changer ainsi le monde plus vaste.

On trouvera à l'encadré 7 un résumé de ses réalisations; une description plus détaillée est fournie sur l'excellent site Web de la communauté - www.ouje.ca/

Encadré : L'histoire d'Oujé-Bougoumou

Voici quelques extraits tirés du site Web de la communauté d'Oujé-Bougoumou à l'adresse www.ouje.ca/

« [...] Notre communauté a entrepris un périple spectaculaire pour la faire sortir des conditions sordides et marginales habituellement associées au tiers-monde, afin de pouvoir vivre dans un village autochtone modèle empreint d'optimisme et tourné vers l'avenir » – Le chef, Sam Bosum

Notre population

La population d'Oujé-Bougoumou est la meilleure ressource dont dispose la communauté. Chaque personne ici possède une vaste expérience de vie et a d'étonnantes histoires à raconter.

Nos aînés avaient une vision : une communauté pour leurs enfants et leurs petits-enfants. Cette vision les a soutenus dans leur lutte pour réaliser leur rêve.

Les aînés de la nation crie d'Oujé-Bougoumou nous ont beaucoup donné : ils nous ont fait profiter de leurs sages conseils; ils ont préservé notre sens de la communauté contre toute probabilité; ils nous ont donné le courage de continuer à lutter et ils nous ont donné un sens de la perspective et une orientation chaque fois que nous en avons eu besoin. C'est sans doute la génération plus jeune qui construira le village, mais c'est la génération des aînés qui a été celle qui a protégé et défendu notre communauté.

Notre jeunesse

Lorsque nous parlons de développer nos compétences et d'acquérir l'instruction nécessaire pour construire notre communauté, la rendre viable et atteindre notre objectif d'autosuffisance, c'est de notre jeunesse que nous parlons.

Ce sont nos jeunes qui profiteront des véritables occasions de bénéficier de l'enseignement postsecondaire et d'obtenir une formation très spécialisée dans les domaines qui contribueront au bien-être de nos communautés.

En réalité, l'avenir de notre communauté appartient à nos jeunes.

Notre vision

Lorsque nous avons commencé à sérieusement planifier notre nouveau village, nous avions une vision. C'était essentiellement de retrouver autant que possible le bien-être de notre vie traditionnelle dans le contexte d'installations modernes et d'établissements contemporains.

Grands objectifs

Au moment de planifier le nouveau village, nous avons défini trois grands objectifs :

- Notre village devait être construit en harmonie avec notre environnement et refléter la philosophie traditionnelle de conservation des Cris.
- Notre village devait pourvoir aux exigences financières à long terme de notre peuple.
- Notre village devait être le reflet de la culture crie dans son apparence et dans ses fonctions.

Encadré 7 – suite

Nous nous sommes rendu compte assez rapidement que, si nous réussissions à concrétiser notre vision, notre village au complet deviendrait une espèce de centre de guérison de beaucoup plus que des simples maux physiques. Si nous pouvions structurer notre nouveau village et notre nouvel environnement d'une manière qui réponde aux différents besoins de notre peuple, nous obtiendrions une population en santé, en sécurité, confiante et optimiste, fière d'être en mesure de relever n'importe quel défi.

Conception innovatrice d'une nouvelle communauté

Voici certains éléments clés de la conception physique et sociale élaborée par la population d'Oujé-Bougoumou.

Conception et architecture

Si les gens d'Oujé-Bougoumou sentent que leur nouveau lieu d'habitation leur donne du pouvoir, c'est parce qu'ils sont intimement liés à sa conception, à sa création et à sa construction, et parce que le village est le reflet véritable de leur culture et de leur style de vie. *Canadian Geographic* (juillet/août 1994) a qualifié la nouvelle communauté de « réalisation sans précédent au Canada – un établissement autochtone caractérisé par la cohérence et l'intégrité ». [Traduction]

- Programme de logement
- Programme d'énergie de remplacement
 - Système de chauffage centralisé – Chaufferie

Sur la voie de l'autosuffisance

- Développement économique
- Harmonie avec l'environnement
- Ressources forestières
- Tourisme culturel
- Développement de l'artisanat communautaire et autres petites industries

Services communautaires pour le développement social

- Le Centre de guérison
- Justice alternative

Préservation de notre identité culturelle

Les communautés de la nation crient d'Ecyou Astchee, guidées par leurs aînés, ont décidé qu'il y aurait à Oujé-Bougoumou un édifice renfermant toutes les agences existantes actuellement chargées d'établir des programmes de préservation de la culture et de la langue. On construira également des installations supplémentaires pour présenter des artefacts historiques et des oeuvres d'art reflétant la culture crie. En cri, le nouvel institut s'appellera Anischaaugamikw, ce qui signifie « transmission d'une génération à l'autre ».

5.5 Gouvernance urbaine saine

La Commission des déterminants sociaux de la santé de l'OMS a établi un nombre de « réseaux de savoirs » – groupes d'experts du monde entier, dont l'un porte sur les établissements urbains. Bien qu'elle ait largement porté sur la situation déplorable d'un milliard de personnes qui vivent dans des taudis et des établissements de fortune, l'analyse du réseau du savoir portant sur la manière dont il faudrait organiser la gouvernance urbaine afin d'améliorer la santé de la population s'applique aussi aux villes de pays industrialisés comme le Canada.

Voici dans l'encadré 8 quelques extraits essentiels du rapport du réseau des savoirs sur les établissements urbains.

Encadré 8 : Our cities, our health, our future: Acting on social determinants for health equity in urban settings

Report to the WHO Commission on Social Determinants of Health from the Knowledge Network on Urban settings – préparé par le Centre de l'OMS pour le développement sanitaire, Kobe, Japon - **Président et rédacteur principal** : Tord Kjellstrom

http://www.who.int/social_determinants/resources/knus_report_16jul07.pdf

Gouvernance urbaine saine

Le réseau des savoirs sur les établissements urbains de l'OMS, établi par la Commission des déterminants sociaux de la santé de l'OMS désigne la « saine gouvernance urbaine » comme les systèmes, les institutions et les processus qui favorisent un niveau de santé plus élevé et une répartition plus équitable des ressources sanitaires dans les milieux urbains, et comme un chemin critique pour améliorer la santé de la population urbaine. Les principaux éléments d'une saine gouvernance urbaine sont les suivants :

- Placer l'équité en santé et le développement humain au centre des actions et des politiques gouvernementales d'urbanisation.
- Reconnaître le rôle critique et charnière que jouent les gouvernements locaux pour assurer la prestation de services de base adéquats, l'accès au logement et aux services de santé ainsi que des milieux urbains où les gens vivent, travaillent, apprennent et se divertissent plus sûrs et plus sains.
- S'appuyer sur les efforts que font les pauvres des régions urbaines au niveau de la communauté pour prendre en main leur situation et contrôler les ressources dont ils ont besoin pour se créer de meilleurs cadres de vie et avoir accès aux services de soins de santé primaires, et soutenir leurs efforts.
- Mettre au point des mécanismes qui réunissent les secteurs public, privé et la société civile pour définir les rôles et les mécanismes permettant aux intervenants nationaux et internationaux d'appuyer la capacité de gouvernance locale.
- Obtenir et utiliser des ressources – aide, investissement, prêts – des intervenants en amont pour assurer l'équilibre entre le développement économique, social, politique et culturel et établir des mécanismes de soutien de la gouvernance qui permettent aux communautés et aux gouvernements locaux de créer, dans le cadre de partenariats, des établissements humains plus sécuritaires et plus sains dans les villes.
- Établir des mécanismes de rétroaction appropriés permettant aux communautés de faire rapport de leur satisfaction ou de leur insatisfaction quant aux interventions en vue de favoriser leur habilitation et leur permettre de se prendre en main, et d'assurer que les objectifs prioritaires et les besoins particuliers de chaque communauté sont pris en compte. (p. 18)

Encadré 8 – suite

Deux autres éléments clés ont été définis ultérieurement :

- Les ordres supérieurs de gouvernement ont donné aux gouvernements locaux le mandat et les moyens d'améliorer la santé;
- L'adoption d'un processus de budgétisation participative et d'autres processus de mobilisation civique comme moyens importants de mobiliser la communauté locale. (p. 50)

Selon le réseau des savoirs sur les établissements urbains de l'OMS, les éléments suivants permettent d'assurer une bonne gouvernance :

1. *Évaluation du contexte urbain* – évaluer les problèmes d'équité actuels en matière de santé urbaine et leur incidence sur la santé, l'importance de la place qu'occupe l'équité en santé urbaine dans le programme politique du gouvernement, le calendrier et le caractère urgent de la mise en œuvre des stratégies et politiques de santé sous-jacentes.
2. *Identification des intervenants* – indiquer clairement les personnes, les groupes et les organisations qui jouent un rôle dans la santé urbaine et qui ont un contrôle sur les répercussions sur la santé urbaine.
3. *Renforcement de la capacité d'action et de création de capital social et de cohésion sociale des intervenants*, étant donné que le changement de politique exige de posséder les connaissances, les compétences et les ressources en place nécessaires.
4. *Évaluation des institutions et création de possibilités d'établir des alliances et d'assurer une collaboration intersectorielle*, étant donné que ce sont les institutions qui déterminent les cadres dans lesquels les changements de politique auront lieu.
5. *Mobilisation des ressources* nécessaires au changement social. Cela peut exiger une meilleure répartition des ressources.
6. *Mise en œuvre, y compris le renforcement de la gouvernance du côté de la demande* : obtenir la participation de la population et l'évaluer dans une perspective organisationnelle et juridique, en tenant compte de la question de l'accès à l'information et aux données pouvant permettre d'assurer la responsabilisation sociale.
7. *Recommandation d'améliorer et de modifier la politique*, et intervention auprès des intervenants responsables de différents niveaux.
8. *Surveillance et évaluation du processus et des impacts* notamment des possibilités d'établir des mécanismes de surveillance dès le début. (p. 39 – 40)

5.6 Création d'une infrastructure pour la gouvernance urbaine

Sherri Torjman (2007) fait valoir dans « Communities Agenda » que la principale tâche des communautés est d'améliorer les liens entre les principaux intervenants, les principaux secteurs, et entre les communautés et les gouvernements. Dans le chapitre « Organizing for complexity », elle soutient que la principale tâche consiste à établir un processus décisionnaire local multisectoriel qui permet d'élaborer un plan exhaustif à long terme pour aborder les problèmes communautaires en s'appuyant sur les forces et les capacités existantes (p. 33).

Toutefois, elle relève (tout comme d'autres, voir les commentaires des intervenants clés) que

« il existe un sérieux « écart en matière de gouvernance » – un décalage entre la complexité des problèmes locaux et la capacité correspondante de les régler ». (p. 40)

Elle fait remarquer, en outre, que la gouvernance communautaire repose sur des fondements plus larges, plus divers, et qu'elle a tendance à voir à plus loin que le gouvernement municipal, ce qui est une force mais pose également des défis.

En adoptant une approche exhaustive et à long terme, ces processus et structures de gouvernance communautaire semblent contrer l'approche à court terme fragmentaire trop souvent utilisée dans les programmes et le financement des gouvernements de tous les ordres et de nombreux bailleurs de fonds philanthropes. Torjman fait valoir que ces solutions fragmentaires ne peuvent pas bien fonctionner dans un monde où tous les éléments sont intrinsèquement liés parce qu'elles sont trop rarement holistiques ou préventives et qu'elles supposent trop souvent que les gouvernements peuvent résoudre à eux seuls tous les problèmes, (p. 43-44).

Selon Torjman, un aspect important de cette nouvelle structure de gouvernance communautaire est qu'elle exige un nouveau style de leadership ainsi que des dirigeants capables de cerner avec efficacité les enjeux et d'élaborer une vision perspicace, qui axent leurs efforts sur l'établissement de liens, de réseaux et de confiance, et partagent le mérite avec les autres. Il s'agit de compétences en leadership qui peuvent s'enseigner et qui doivent l'être.

Torjman relève également que ces structures de gouvernance communautaire exigent beaucoup de temps, d'énergie et de ressources, ce qui signifie qu'elles doivent bénéficier d'un bon soutien à long terme. Pourtant, elles doivent simultanément démontrer leur rapidité d'action et leur efficacité dans le contexte de leurs plans plus vastes pour être crédibles et conserver leur crédibilité auprès de la communauté et des bailleurs de fonds.

Il s'agit de toutes les leçons apprises il y a longtemps par les conseils de planification sociale, les projets de communautés saines et bien d'autres projets qui abordent ce que Neil Bradford appelle les « problèmes pernicioeux » (*wicked-problems*) des défis complexes, à long terme, posés à la résilience communautaire et au bien-être des êtres humains. La création de nouveaux processus et de nouvelles structures de gouvernance communautaire exige une approche très différente de la part du gouvernement et des bailleurs de fonds philanthropes.

6. Obstacles à la gouvernance communautaire et à l'action communautaire pour la santé et le développement humain

Si donc pendant de nombreuses années la nécessité de nouveaux processus, de nouvelles structures et d'un nouveau financement était claire pour de nombreux intervenants participant au « programme communautaire », pourquoi ces changements ne sont-ils pas produits à grande échelle au Canada? L'affaiblissement de l'engagement politique, comme ce fut apparemment le cas pour l'Accord de Vancouver, n'est que l'un des obstacles potentiels de l'action communautaire pour la santé et le développement humain.

La recherche et les entrevues menées avec plusieurs intervenants clés²¹ bien au fait de ces efforts et d'autres efforts déployés au niveau national pour mettre en place un programme communautaire reposant sur une large base au Canada ont permis de définir un nombre d'obstacles à l'adoption d'une approche axée sur la communauté plus ferme pour améliorer le niveau de santé et de développement humain.

6.1 Approche fragmentaire aux problèmes communautaires – nécessité d'une approche plus exhaustive

L'un des thèmes qui sont ressortis le plus fréquemment des ouvrages sur le sujet (voir, par exemple, la section 5.6) et des entrevues avec les intervenants clés est que l'approche actuelle fragmentaire et cloisonnée adoptée pour résoudre les problèmes communautaires ne fonctionne pas. Comme l'a indiqué un intervenant clé :

« Nous disons que tout est dans tout ». Tout est interdépendant. On ne peut créer une collectivité dynamique en ne se concentrant que sur une chose. Tout se fait dans le cadre de projets, mais en fait nous devrions penser dans le contexte du système global ».

Un autre intervenant a fait remarquer :

« C'est vraiment tout un travail en soi, prendre des décisions, planifier, veiller à ne pas s'écarter de la voie tracée. Tenter d'établir une initiative complexe morceau par morceau, et de plus une initiative intégrée dont il faut s'assurer que tous les morceaux fonctionnent ensemble. Cette intégration de la prise de décision manque en soi de soutien ».

6.2 Absence de vision nationale d'ensemble

Comme nous l'avons noté à la section 5, un nombre de nouvelles initiatives ont recours à des approches reposant sur les actifs ou sont axées sur la collaboration pour aborder les déterminants de la santé. Bien qu'individuellement, toutes ces organisations fassent du bon travail dans leurs communautés respectives, il existe le risque de chevauchement des efforts. Toutefois, l'absence apparente d'une seule vision d'ensemble du rôle et de la fonction de la communauté, de la part du gouvernement fédéral ou des gouvernements provinciaux est plus préoccupante. Cela témoigne du trop fréquent manque de soutien au niveau national ou provincial pour une approche exhaustive et habilitante qui aiderait la communauté à définir ses propres

Commentaires d'intervenants clés à propos d'une vision (nationale) commune

[Traduction] « Notre gouvernement fédéral n'a pas vraiment adopté de politiques et de principes directeurs à l'égard du secteur social ou de la société civile ».

« Nous en concluons que nous devons nous-mêmes nous organiser différemment [...] Nous devons continuer de faire ce que nous faisons, mais nous devons avoir une vision commune de ce que nous souhaitons être et nous devons ensuite trouver une meilleure façon de réaliser cette vision et nous voir en train de mettre en œuvre cette vision au lieu de 100 visions différentes ».

²¹ On trouvera la liste des intervenants clés que nous avons interrogés à l'Annexe 3

problèmes et à trouver ses propres solutions. La nature des règlements qui limitent les activités des organismes caritatifs, comme nous le décrivons dans la prochaine section, est un exemple de manque de soutien des infrastructures au niveau national.

L'un des thèmes connexes qui se sont dégagés a trait au fait que la grande importance qu'accorde le Canada au système de soins de santé de courte durée nuit aux initiatives communautaires qui visent à améliorer la santé des populations, non seulement aux priorités gouvernementales, mais aussi au secteur qui travaille dans le secteur de la santé. Comme l'a fait remarquer un intervenant clé :

- « Les intervenants du secteur de la santé n'ont pas accordé un soutien suffisant aux intervenants du secteur social. [...] Il se peut qu'ils réparent les dégâts causés par la société aux individus, mais ils ne semblent pas emprunter la voie de la prévention avec nous, ni soutenir fermement l'accès à un logement convenable, les stratégies de réduction de la pauvreté; etc. Ce que je vois se produire actuellement dans nos communautés – le vrai travail sur la santé est souvent fait en dehors du secteur de la santé, dans la société civile, dans les organismes sociaux, par exemple. Les deux ne communiquent pas entre eux. Je pense que c'est une vraie tragédie. Ceux d'entre nous qui travaillent dans le domaine de la santé et le secteur social doivent considérer les problèmes de façon exhaustive, dynamique. Nous devons prendre en compte l'interdépendance des dimensions sociales, économiques et de la santé. Faire moins n'est plus suffisant ».

6.3 Ententes municipales dépassées

Ces dernières années, un nombre d'écrivains, d'universitaires et d'organisations a noté qu'il fallait modifier les accords fiscaux et constitutionnels avec les municipalités pour aborder les problèmes de plus en plus complexes de la société urbaine.

Judith Maxwell, présidente des Réseaux canadiens de recherche en politiques publiques a écrit en 2006 :

« Les gouvernements locaux font face à tous les problèmes complexes et à toutes les possibilités du XXI^e siècle, mais ils sont forcés d'agir conformément aux pouvoirs financiers et législatifs d'une constitution du XIX^e siècle. Dans ces conditions, leur seul espoir réside dans un leadership visionnaire, des citoyens pleinement engagés et des hauts fonctionnaires réceptifs. Il faut que les dirigeants puissent faire changer les choses – non seulement au niveau du gouvernement local, mais dans toute la communauté – dans les entreprises, le monde de l'éducation, les organismes sans but lucratif et dans les groupes communautaires et de citoyens »²².

Neil Bradford, professeur en sciences politiques à l'University of Western Ontario et associé en recherche aux Réseaux canadiens de recherche en politique publique a fréquemment écrit sur le nouveau pacte nécessaire pour les municipalités (Bradford 2002,

²² Extrait de *Toward the Tipping Point : Aligning the Canadian Communities Agenda*, p. 11, que l'on peut consulter à l'adresse <http://www.ccl-cca.ca/NR/rdonlyres/301F7CD2-2EF6-4914-9CB0-40E3AD42C100/0/2007091920TippingPoint.pdf>

2004, 2007). Il observe que les gouvernements canadiens doivent surmonter des blocages constitutionnels, des rivalités politiques et des accords financiers d'un autre âge pour collaborer à un nouveau programme urbain. Bradford déclare qu'il s'agit du seul moyen pour que l'économie canadienne puisse rivaliser avec les autres villes du monde entier qui offrent une grande qualité de vie à leurs citoyens (Bradford, 2002).

Bradford affirme que ce ne sont pas un ou deux intervenants qui pourront à eux seuls régler les problèmes de plus en plus complexes qui influent sur la qualité de vie dans nos villes. Il faut abandonner les approches cloisonnées, segmentées, traditionnelles pour adopter une politique publique dirigée par la collectivité enracinée dans une « gouvernance multipaliers axée sur la collaboration ». Pour cela, il faut un nouveau cadre de politique urbaine qui reconnaisse la complexité des problèmes stratégiques, qui mette à profit les *connaissances et les ressources locales*, qui se caractérise par une *collaboration horizontale* au sein des villes et des collectivités et par une *collaboration verticale* dans tous les ordres de gouvernement – comme l'Accord de Vancouver, mais qui puisse exister à long terme. (Bradford 2007)

La Fédération canadienne des municipalités (FCM) a également émis un nombre d'énoncés de politique demandant avec instance un nouvel accord avec le gouvernement fédéral et les gouvernements provinciaux. Dans son énoncé de politique sur les engagements intergouvernementaux sur les finances municipales (FCM 2008), la FCM observe qu'il existe un écart croissant entre les services que les municipalités du Canada doivent offrir et ce qu'elles peuvent se permettre d'offrir. Par comparaison avec d'autres ordres de gouvernement, les administrations municipales canadiennes ont bien moins de possibilités de percevoir des revenus. Les municipalités des États-Unis et des autres pays de l'OCDE ont des moyens plus divers, généreux et souples de percevoir des fonds que les municipalités canadiennes.

L'énoncé de politique de la FCM relève qu'un rapport fait en 2002 sur le Canada par l'OCDE conclut que « la forte dépendance » des administrations municipales canadiennes aux impôts fonciers est la source de leurs difficultés financières croissantes. Ce rapport indique également que les villes canadiennes ont « des pouvoirs et des ressources relativement faibles » et qu'on devrait leur donner un certain accès limité à d'autres types d'impôts pour leur permettre de s'acquitter de leurs responsabilités croissantes. Sur chaque dollar perçu au Canada en impôt, seulement huit cents (principalement en impôts fonciers), vont aux municipalités alors que le 92 p. 100 restant va aux gouvernements fédéral et provinciaux.

On y relève également que ces dix dernières années, les gouvernements provinciaux et territoriaux se sont déchargés de leurs responsabilités sur les administrations municipales sans leur transférer les ressources financières correspondantes. Les municipalités fournissent aujourd'hui des services de soutien à l'immigration, à l'environnement, aux Autochtones, au logement abordable, à la santé publique, à la préparation aux situations d'urgence et à la sécurité publique sans avoir reçu de fonds supplémentaires. De plus, ces dix dernières années, les transferts de fonds n'ont pas été proportionnels à la hausse du coût de la vie ou à ces responsabilités accrues. La FCM fait observer que de 1999 à 2003, les recettes du gouvernement fédéral ont augmenté de 12 pour cent, les recettes des provinces et des territoires, de 13 pour cent, et celles des municipalités de seulement huit pour cent. En 1993, les transferts représentaient 25 cents pour chaque dollar de

recettes municipales, en 2004, ils n'en représentaient que 16, soit une baisse de 37 pour 100.

La solution, observe l'énoncé de politique, réside en un accord constitutionnel différent et plus de latitude pour percevoir des fonds, au moyen notamment de la perception d'une partie de la taxe sur les ventes, d'une partie de l'impôt sur le revenu, de la taxe sur l'essence et des frais imposés aux usagers.

6.4 Absence de structure communautaire pour la gouvernance

Il s'agit de l'inverse de la nécessité d'établir un processus et une structure pour la gouvernance communautaire dont nous avons parlé à la section 5.6. Comme l'a fait observer un intervenant clé :

« Les bailleurs de fonds ne veulent pas financer ce processus [parce qu'ils pensent] qu'il n'y a rien à en retirer. Mais c'est comme de dire que l'on peut mettre en place une politique sans avoir de débats à la Chambre. Qu'il suffirait de mettre en place cette politique sans qu'il y ait de comité, de délibérations, il suffirait de la mettre en place. C'est pareil dans les communautés. Cela revient à dire, allez-y! faites vos programmes, mais le temps manque pour que vous vous rencontriez pour planifier ou mener une évaluation ».

6.5 Limites du financement

Du fait qu'une grande partie de l'activité de promotion de la santé et du développement communautaires est menée actuellement par les organismes caritatifs enregistrés, un problème constant est l'accès à un financement stable. Le récent ralentissement de l'activité économique a rendu la nécessité d'obtenir les fonds limités encore plus pressante. La plupart des fondations familiales et communautaires du Canada qui accordent des subventions ont perdu jusqu'à 30 % de la valeur de leurs dotations, ce qui limite grandement leur capacité de fournir des subventions. Les donateurs privés connaissent eux aussi une réduction de la valeur des actifs dont ils peuvent faire don à des causes méritoires. Les subventions gouvernementales sont elles aussi en train de fondre et elles sont souvent axées sur un objectif prioritaire d'un projet et n'appuient pas le modèle de planification reposant sur les actifs pour les processus de réunion et de mobilisation communautaire, car il ne s'agit pas des objectifs prioritaires de leurs programmes ou services. Il y a des fonds pour les projets pilotes, mais si ceux-ci se révèlent efficaces, le financement manque pour les mettre en œuvre à une plus grande échelle. La nécessité de présenter constamment des demandes aux fondations ou aux programmes de subventions peut prendre beaucoup de temps, temps qui est consacré à une activité qui ne sert pas essentiellement à résoudre les problèmes communautaires qui se posent. Les besoins financiers peuvent empêcher de coopérer et de collaborer au développement communautaire en cours du fait que les organisations se livrent concurrence pour obtenir les mêmes fonds.

Commentaires de certains intervenants clés au sujet du financement [Traduction]

« Le financement crée des tensions entre les gens. En fait, il détruit certaines relations sociales. Les gens veulent recevoir l'argent ».

« Le fédéral doit prévoir des modes de financement souples pour que les collectivités qui reçoivent des fonds pour la santé puissent les utiliser de façon créative ».

« Il n'y a pas de fonds pour financer un organisme décisionnaire ou une structure de gouvernance, ou une table locale, peu importe son nom, qui se réunit pour prendre des décisions sur l'approche globale à élaborer. Il arrive souvent que ce soit la collectivité elle-même qui doive s'occuper du processus. À moins qu'elle ne trouve des fonds pour le faire, ou que quelqu'un lui offre un de ses employés pour y consacrer un peu de temps; mais en l'absence d'une aide permanente, le processus finit par stagner ».

« Les fonds qui ont tendance à être disponibles vont aux projets individuels à court terme qui sont ancrés dans un seul service, un seul ministère. Si l'on a adopté une approche intégrée qui croise et fait intervenir plusieurs services, il est souvent difficile d'obtenir du financement pour ça. Chaque service finance son propre travail. Je sais, ayant participé à un certain nombre de projets qui cherchaient à transcender cette approche gouvernementale unidimensionnelle, que nous avons toujours été obligés de revenir à ce très traditionnel modèle vertical. »

« Tout n'est pas rose dans le monde des partenariats multiréseaux. Le décideur public souhaite toujours avoir un grand contrôle sur l'argent qu'il transfère. Il s'agit toujours de fonds accordés pour s'acquitter d'un mandat public. Il y a toujours un grand contrôle. L'évaluation de ces programmes fondés sur l'octroi de fonds publics aux organismes communautaires, les questions entourant les évaluations concernant ces programmes sont énormes, et la plupart d'entre elles sont contradictoires [...] si l'on affecte les fonds à des projets spécifiques, régionaux ou locaux, on menotte alors les gens et on va assister à une intéressante bagarre politique ».

« Les représentants de cinq différents ministères fédéraux se sont rencontrés pour travailler sur cette approche de revitalisation des quartiers. [...] Essentiellement, ils ont dit, « nous souhaitons qu'elle soit orientée sur les citoyens et menée par la communauté ». En même temps, chaque partie disait en substance, « mais nous voulons que vous agissiez dans le secteur qui nous intéresse. De combien de toxicomanes vous êtes-vous occupés? Et le service de l'alphabétisation souhaite savoir ce que nous avons fait dans le domaine de l'alphabétisation. » C'est donc paradoxal. D'un côté, on dit : « Oui, laissons la communauté définir ce qu'elle souhaite faire » et de l'autre, le gouvernement dit « toutefois, elle doit travailler sur XYZ, parce que c'est ça qui nous intéresse ».

« Les problèmes au niveau du financement, de la reddition de comptes, du calendrier à long terme qui est requis, sont considérables. Les initiatives en place sont habituellement des initiatives à court terme ».

« Les fonds philanthropiques portent préjudice au développement social. Le financement philanthropique ne tient pas compte d'un cadre comme celui des collectivités en santé, par exemple, ou des déterminants sociaux de la santé, ou de l'inclusion. Il ne s'agit pas d'un service direct. Ils ne sont pas destinés à la prévention, à trouver la raison pour laquelle les gens en sont arrivés là, ou à comprendre. Ils ne cherchent qu'à fournir un service. [...] ils ne souhaitent pas financer des organismes intermédiaires [...] ou des processus [...] ou de la recherche et développement ».

Toutefois, au-delà des problèmes que posent les niveaux de financement, nos intervenants clés se préoccupaient davantage de l'approche concernant le financement

adoptée actuellement, notamment du fait qu'elle est trop souvent fragmentaire, à court terme, réductionniste, et de nombreux commentaires témoignent de ces préoccupations.

6.6 Absence de consensus sur le soutien pour plus de programmes universels

Selon un certain nombre d'intervenants, la promotion de la santé et le développement humain seraient bien plus efficaces s'il y avait des données de référence pour les programmes universels qui permettraient d'aborder les déterminants de la santé dans l'ensemble du pays. On pourrait alors fonder les activités de promotion de la santé sur cette base solide. Dans son rapport de 2008 sur les déterminants sociaux de la santé, l'Organisation mondiale de la santé indique que les pays nordiques offrent un soutien bien plus grand aux programmes universels, ce qui a permis de réduire les inégalités sociales et les problèmes de santé causés par l'inégalité d'accès aux déterminants de la santé.

Commentaires d'intervenants clés sur les programmes universels

« Avec les programmes communautaires, nous risquons de perdre de vue l'importance des programmes universels ».

« Ils posent un problème de base épineux au Canada. En effet, comment pouvons-nous promouvoir la satisfaction des besoins locaux en encourageant simultanément un panier de services canadiens? Comment traiter équitablement tous les Canadiens tout en répondant aux besoins locaux? Je ne crois pas que nous ayons réussi à trouver une réponse entièrement satisfaisante au Canada ».

Les auteurs d'un nombre d'ouvrages récents sur la santé de la population et ses déterminants s'entendent généralement pour dire que le développement de la petite enfance est un élément constitutif fondamental de la santé et du développement humain et qu'il faut avoir des programmes de garde d'enfants universels de grande qualité qui appuient le développement et l'éducation de la petite enfance pour tous les enfants canadiens, quel que soit le revenu de leurs familles.

Mais Torjman (2007) invite à la prudence

« Le programme communautaire ne réduit aucunement la nécessité d'un ensemble solide de services et de biens publics. Les actions communautaires supplémentent et complémentent à la fois les politiques publiques axées sur le mieux-être socio-économique, elles ne les remplacent pas. » (Torjman, 2007, p. 3)

6.7 Limites imposées par les règlements sur les organismes caritatifs et sur l'investissement social

La plupart des organismes non gouvernementaux, sinon tous, qui œuvrent au niveau communautaire sur les déterminants de la santé sont des organismes canadiens enregistrés. Ils reçoivent une grande partie de leurs fonds, souvent plus de 80 %, de fondations communautaires ou familiales et de donateurs privés. L'Agence canadienne du revenu (ACR) réglemente les organismes caritatifs

Commentaires d'intervenants clés sur les règlements concernant les organismes caritatifs

Un intervenant clé a fait remarquer que la législation sur les organismes caritatifs agréés limite l'éventail d'activités d'un important programme national qui reçoit 85 % de son financement de fondations philanthropiques. Il (elle) a dit qu'il leur avait fallu travailler avec Revenu Canada pour que leur communauté puisse être soustraite de l'application de certains règlements, en particulier pour que les individus puissent bénéficier des retombées positives de la réduction de la pauvreté.

agréés aux termes de la *Loi de l'impôt sur le revenu* et tous ces organismes doivent gérer leurs activités conformément à cette loi. Pourtant, cette loi est aujourd'hui dépassée et elle retarde le travail innovateur que fait le secteur caritatif au chapitre des problèmes sociaux et du développement communautaire. Les entrevues avec les intervenants clés ont également soulevé la question des règlements dépassés et rigides qui entravent l'innovation et la prestation des services qui sont imposés aux organismes caritatifs.

Dans un discours intitulé « Laisser libre cours au pouvoir de l'entreprise sociale », l'ex-premier ministre et ministre des Finances Paul Martin appelait à une révision de la *Loi de l'impôt sur le revenu*, en particulier pour encourager l'innovation sociale, les entreprises sociales et l'entrepreneuriat, et l'investissement communautaire : « [...] les limites historiques qu'elles fixent [les règles de la *Loi de l'impôt sur le revenu*] pose aujourd'hui problème, car elles n'ont pas suivi l'évolution du domaine social qu'elles cherchent à servir » (Martin, 2007).

Martin s'intéresse particulièrement à la promotion de l'indépendance économique des Autochtones canadiens en soutenant et en encadrant les entrepreneurs autochtones au moyen d'investissement dont ils retirent peut-être un rendement financier inférieur au marché, mais un rendement social élevé. « Le problème fondamental est qu'il existe au Canada, une démarcation très nette entre, d'une part, les organismes de bienfaisance sans but lucratif et, d'autre part, l'investissement du secteur privé ». Martin a relevé que cette ligne de démarcation rigide entre les organismes de bienfaisance et les entreprises sociales nuit à l'atteinte des objectifs sociaux du Canada ».

Une étude récente, *Canadian Registered Charities : Business Activities and Social Enterprise – Thinking Outside the Box* (Carter & Man, 2008) relève que l'ARC, dans le cadre de sa directive RC4143 (F) *Les organismes de bienfaisance enregistrés et les programmes de développement économique communautaire*, ne permet pas certaines entreprises sociales —et ce qui est permis est « extrêmement restrictif et ne répond plus aux besoins des vastes activités d'entreprise sociale qui sont menées dans le monde entier ».

Voici certains exemples d'autres pays :

- Les États-Unis permettent maintenant aux fondations d'investir dans des entreprises sociales à partir de leurs fonds de dotation sans que cela n'affecte leur statut d'organisme de bienfaisance. Ces investissements reliés aux programmes sont autorisés dans la mesure où le rendement social est l'objectif principal. Les États du Vermont et de la Caroline du Nord permettent aux investisseurs habituels, non seulement aux fondations, d'investir dans des entreprises sociales par l'entremise d'organismes de bienfaisance.
- Les États-Unis ont créé le crédit d'impôt pour nouveaux marchés en vertu de la *Community Renewal Tax Relief Act* de 2000. Ce programme de crédit d'impôt pour nouveaux marchés prévoit des investissements d'environ 15 milliards de dollars dans des organismes de placement gérés par des particuliers appelés « entités de développement communautaires (EDC) » qui consentent des prêts et investissent dans des entreprises de régions mal desservies. En investissant dans une EDC, un investisseur particulier ou de société peut avoir droit à un crédit d'impôt équivalant à 39 pour cent (30 pour cent de la valeur actuelle nette) de

l'investissement initial, réparti sur une période de sept ans, ainsi qu'à tout rendement sur son investissement dans l'EDC.

- En 2005, le Royaume-Uni a instauré un nouveau type de société baptisé « entreprise d'intérêt communautaire » (EIC) créée à destination de personnes qui souhaitent diriger une entreprise pour le bien de la communauté et pas seulement pour en tirer des avantages personnels. Des tests d'intérêt communautaire et le verrouillage des actifs permettent de s'assurer que l'EIC est constituée à des fins communautaires et que ses actifs et ses profits sont déployés en conséquence. L'enregistrement d'une EIC doit être approuvé par l'organisme de réglementation qui assume également un rôle de surveillance et de renforcement continus. En mars 2009, on comptait 2 578 EIC enregistrées au Royaume-Uni²³ et ce nombre augmente d'au moins 100 par mois.

Imagine Canada²⁴, organisme caritatif porte-parole du secteur caritatif, relève que le Canada compte 161 000 organismes caritatifs enregistrés et organismes sans but lucratif qui regroupent plus de 12 millions de bénévoles fournissant deux milliards d'heures de bénévolat. Ces organismes emploient un effectif de 2 millions de travailleurs équivalents temps plein – 11 % de la population économiquement active – ce qui représente 8,5 % du PIB du Canada. Un grand nombre de ces organismes caritatifs œuvrent au service de l'équité sociale, du renforcement communautaire ou d'autres activités qui accroissent le capital social. Il s'agit d'un terrain fertile que le gouvernement canadien peut explorer pour trouver de nouveaux mécanismes législatifs et des incitatifs fiscaux visant à soutenir cette main-d'œuvre appréciable et mettre à profit son enthousiasme et son engagement pour aborder les déterminants de la santé.

6.8 Épuisement du secteur bénévole

Une grande partie de l'activité communautaire est menée par les organismes caritatifs qui dépendent de l'enthousiasme et de la mobilisation des bénévoles. Toutefois, le travail n'est pas facile. Il consiste souvent à aider les individus et les communautés qui ont de graves problèmes sociaux. Le niveau de stress est élevé et les interactions sociales peuvent être éprouvantes. Le ralentissement économique augmente le stress du secteur bénévole face au nombre accru de Canadiens qui se retrouvent sans travail ou qui font face à une crise financière. L'épuisement et le roulement élevé du personnel sont courants.

Commentaire d'un intervenant clé sur l'épuisement

Un intervenant clé a observé que le ralentissement économique actuel augmente la probabilité d'épuisement : « Ceux d'entre nous qui travaillent dans ce secteur savent que nous ne pourrions pas répondre aux besoins qu'auront les gens. Et cela nous désespère. Nous savons que nous n'avons pas les ressources financières et humaines nécessaires. À mesure que les gens quittent le secteur, nous allons nous retrouver sans les personnes qui peuvent le mieux faire le travail. Nous vivons vraiment un moment de désespoir [...] Nous sommes, pour ainsi dire, écrasés par ce qui arrive ».

²³ Pour avoir plus d'information sur les EIC consulter le site www.cicregulator.gov.uk

²⁴ Voir le communiqué à l'adresse

http://www.imaginecanada.ca/files/en/publicaffairs/budget_2009_response_release_20090127.pdf

6.9 Difficultés à mettre en commun les cas de réussite au Canada

Commentaire d'un intervenant clé sur les échanges d'information

« En tant que Canadiens, nous n'avons pas encouragé, largement à notre détriment, un mouvement pancanadien. Les échanges d'un continent à l'autre sont coûteux. Et nous ne les avons pas encouragés. Mais surtout, dans le Canada anglais, nous n'avons pas pu connaître certaines réalisations intéressantes qui ont été faites au Québec ».

Un autre obstacle au développement communautaire et à l'engagement à l'égard des déterminants sociaux tient à la nature même du Canada. La dimension géographique, la question linguistique, et les divers cloisonnements provinciaux signifient souvent que des initiatives et des innovations prometteuses dans une province ne sont pas connues dans les autres régions. Il a été observé en particulier, tant dans les études consultées pour les besoins de notre rapport que dans les entrevues menées avec les intervenants clés,

qu'il était très difficile de savoir ce qui se passait au Québec si l'on n'est pas bilingue. De même, une organisation francophone aurait beaucoup de mal à trouver l'information sur des programmes communautaires réussis menés au Canada anglais.

7. Services sociaux communautaires

intégrés

Les approches communautaires aux services sociaux intégrés sont un important sous-ensemble du développement humain communautaire. Le développement humain communautaire est un groupement général d'actions menées au niveau communautaire visant à améliorer la vie des gens et les déterminants de la santé. Les services sociaux intégrés sont un moyen d'aborder le développement humain et d'influer sur les déterminants de la santé en coordonnant les actions des particuliers et des services. Ils ont pour mission de rationaliser et de simplifier leur accès aux clients, d'être plus efficaces, d'offrir des soins de meilleure qualité et d'éliminer les barrières organisationnelles traditionnelles ou les limites des programmes.

Les services sociaux intégrés sont souvent décrits comme un service uniforme « à guichet unique » créé pour que les gens n'aient à fournir leurs renseignements qu'une seule fois. Ce processus vise à éliminer les cloisonnements traditionnels, à favoriser le travail avec d'autres secteurs et à coordonner les activités de services aux clients. Bien qu'il s'agisse d'un modèle axé sur le problème, qui ne repose pas sur les actifs, comme décrit plus haut, son objectif est toujours le travail en partenariat avec le client pour l'habiliter en éliminant les obstacles et en créant des voies hors de la pauvreté, de la mauvaise santé et autres dysfonctionnements.

Commentaires d'intervenants clés sur les services intégrés

Un intervenant clé a observé que cette approche uniforme est particulièrement utile pour le groupe complexe de clients qui représente la population la plus négativement touchée par les déterminants de la santé :

« De nombreuses personnes qui ont besoin de services sont celles qui ont toutes sortes de problèmes et elles ne peuvent pas courir partout pour obtenir différents services. Certaines d'entre elles ont un faible niveau d'instruction, et peut-être des problèmes d'alcoolisme ou de toxicomanie, ou bien elles sont seules pour élever leurs jeunes enfants. Par conséquent, il peut leur être difficile d'avoir accès aux services pour tout un tas de raisons ».

Bien entendu, les services sociaux, même bien intégrés, ne suffisent pas à faire une communauté saine. Cependant, de nombreuses personnes qui ont des problèmes de santé et des problèmes sociaux et besoin de services sociaux trouvent le système actuel complexe, disparate, non coordonné et décevant, situation empirée par le fait que les personnes ayant les plus grands besoins, et besoin de plusieurs services, appartiennent en grand nombre aux groupes défavorisés.

Ainsi, une approche communautaire de la santé et du développement humain globale devrait porter en partie, autant que possible, sur l'intégration des services sociaux, et là où les utilisateurs en ont le plus besoin.

Parmi les exemples de services sociaux intégrés, on peut citer les CLSC du Québec (centres locaux de services communautaires) et les centres de santé communautaires du Canada anglais, que nous décrivons ci-dessous. Nous verrons également l'initiative d'intégration des services à grande échelle de la Saskatchewan.

Comme le fait remarquer Thompson dans une étude exhaustive de l'expérience en matière de services sociaux intégrés au Canada, aux États-Unis et en Grande-Bretagne (Thompson, 2007), l'intégration est un processus et non un simple modèle. Il ne s'agit pas d'une approche pouvant s'appliquer à toutes les situations. Il s'agit plutôt d'un objectif que l'on doit adapter à chaque situation.

Cela étant dit, il y a cependant certains éléments communs qui contribuent au succès de l'intégration des services ainsi que certains obstacles prévisibles qui peuvent saper leur efficacité.

7.1 Services sociaux intégrés - facteurs de succès déterminants et obstacles

Thompson relève que les obstacles à l'intégration sont mentionnés plus souvent que les facteurs de succès et que l'intégration des services n'est pas chose facile. Il a défini les facteurs de succès et les obstacles suivants (Thompson, 2007) :

1. Facteurs qui contribuent à l'environnement dans lequel le développement de services intégrés efficaces est le plus susceptible de se produire :

- **Leadership fort** – Les leaders qui se font les champions de l'intégration et qui sont fortement engagés dans cette approche peuvent vraiment changer les choses. Nous avons besoin de leaders dans toutes les disciplines, au niveau communautaire et au niveau de la haute direction.
- **Structures de gouvernance** – Des mécanismes de reddition de comptes et de gouvernance clairement formulés et bien compris sont des facteurs essentiels au succès de tout partenariat, et ils doivent être approuvés au niveau de la haute direction dès le début de la relation.
- **Mesures de reddition de comptes** – Des mécanismes de reddition de comptes clairement formulés aident à mesurer les progrès et à déterminer si les objectifs sont atteints.
- **Compétences en gestion/gestionnaires chevronnés** – Pour assurer le succès, il est important que les gestionnaires de programme et les membres de la

communauté des services sociaux locale aient de nombreuses années d'expérience et connaissent bien leurs communautés.

- **Mission commune, clairement définie** – Un énoncé de mission claire qui est élaboré par les représentants des organismes partenaires et les membres de la communauté aide à créer des liens solides entre divers particuliers et organismes.
- **Volonté de prendre des risques, d'expérimenter et de changer** – L'intégration des services comporte l'adoption de nouvelles approches et de nouvelles façons de procéder. Il doit y avoir une volonté de prendre des risques et suffisamment de souplesse pour mettre en œuvre des stratégies innovatrices et changer d'orientation lorsqu'une approche ne donne pas les résultats escomptés. Thompson relève que cette attitude est tout à fait à l'opposé de la culture réfractaire au risque qui est caractéristique de nombreux organismes gouvernementaux.
- **Accent mis sur la communauté** – Les communautés doivent participer activement à la prestation des ressources nécessaires pour l'intégration, ce qui veut dire qu'elles doivent également participer à la planification et à mise en œuvre de projets intégrés (Ragan, 2003). Une coalition locale forte peut être une force puissante de changement.
- **Services axés sur les clients/citoyens** – Une approche d'intégration axée sur les clients/citoyens a deux dimensions :
 - **Consultation de la clientèle** – Les consommateurs et autres intervenants doivent être consultés de façon régulière pour connaître leurs besoins et leurs attentes. Les membres de la communauté et les intervenants doivent se sentir suffisamment en confiance et à l'aise pour participer aux consultations, de sorte à pouvoir prendre part, dans la foulée, à des événements et des projets communautaires qui ne posent pas de risques. Au niveau de la gestion des cas, en mettant le client au premier plan, celui-ci sera motivé à participer une fois qu'on lui aura fixé des objectifs et lorsque les équipes de plusieurs programmes analyseront son cas.
 - **Approche fondée sur les forces ou les actifs** – Les processus de gestion des cas et d'évaluation sont fondés sur les forces des familles ou des individus plutôt que sur leurs faiblesses, et les familles sont encouragées à reconnaître leurs forces et à prendre appui sur elles.

2. Facteurs qui font obstacle à l'environnement dans lequel le développement de services intégrés efficaces est le plus susceptible de se produire :

- **Confidentialité de l'information** – Les difficultés réelles et perçues entourant l'échange d'information sur les clients sont l'un des obstacles les plus fréquemment cités. Toutefois, les gestionnaires qui ont abordé cette question disent qu'il peut s'agir d'une tactique de diversion. Il se peut que les employés qui déclarent que les règlements de leurs programmes les empêchent d'échanger des informations invoquent la confidentialité comme prétexte pour résister à l'intégration des services. Selon Ragan (2003), l'échange d'information est particulièrement problématique lorsque différents ordres de gouvernement sont

chargés d'administrer les programmes. Dans cette situation, il peut être nécessaire de consacrer beaucoup de temps et d'efforts pour permettre aux divers ordres de gouvernement de s'entendre et d'établir les mécanismes de sécurité nécessaires pour garantir que seuls les employés qui ont les autorisations nécessaires aient accès à cette information.

- **Résistance au changement et fatigue à l'égard du changement** – Il arrive que les individus, les professionnels et les organismes soient réfractaires au risque. Tout changement exige un certain montant de risque; la prestation de services intégrés exige une transformation de la manière dont les ministères, les organismes, les professionnels et les particuliers mènent traditionnellement leurs activités. L'intégration signifie que chaque participant n'a plus le contrôle d'un processus, mode de prestation, etc., et que ce sont les partenaires qui se partagent maintenant ce contrôle. Il peut y avoir le désir de protéger son territoire et le manque de désir de partager le contrôle. Même lorsque les individus et les organisations appuient initialement le changement, un changement continu important peut susciter de la lassitude par rapport au changement. C'est surtout le cas en périodes de compressions budgétaires ou de personnel. Parfois, les gens n'ont tout simplement pas les ressources, le temps et l'énergie émotionnelle nécessaires pour investir dans un changement subséquent lorsque le résultat est incertain. (New Zealand State Services Commission, 2003; Rutman et coll., 1998)
- **Différences entre cultures organisationnelles** – Différentes organisations, et en particulier différents ministères gouvernementaux, ont des cultures différentes et des façons différentes de mener leurs activités. Ces cultures se sont peut-être développées au cours de nombreuses décennies, peuvent être solidement enracinées et toucher pratiquement tous les aspects des opérations. La culture organisationnelle influe sur les objectifs organisationnels, le degré d'importance accordée aux clients, la terminologie utilisée pour décrire les fonctions et les services, les approches de la gestion des cas, les procédures de communication au sein de l'organisation et avec les groupes externes, et les processus et procédures utilisés dans la planification. Il peut être difficile de surmonter ces différences entre les cultures organisationnelles. Les intervenants doivent d'abord comprendre leurs points de vue mutuels et ensuite trouver un terrain d'entente à partir duquel travailler. Certains experts disent que le moyen le plus facile de le faire consiste à passer outre les objectifs et mandats des organismes existants, de s'entendre sur une orientation commune et un but commun au début de l'initiative d'intégration, d'établir des hypothèses et des objectifs communs qui orienteront le travail futur.
- **Problèmes concernant les ressources** – Plusieurs problèmes concernant les ressources peuvent faire obstacle à l'intégration des services.
 - **Différences entre les capacités et les ressources des partenaires** – Les partenaires plus grands qui ont plus de fonds peuvent avoir l'impression qu'ils sont en droit de contrôler les choses. Toute collaboration véritable exige que les partenaires plus grands fassent passer leurs propres objectifs après ceux du partenariat (Ragan, 2003).

- **S'entendre sur la contribution de chaque partenaire** – Il peut y avoir des divergences d'opinions quant au montant de la contribution que devrait faire chaque partenaire.
- **Difficulté à obtenir du financement** – Il peut être difficile d'obtenir du financement horizontalement dans un système cloisonné. Les ministères peuvent hésiter à fournir des fonds à des projets dont ils ne voient pas d'avantages concrets liés directement à leur ministère.
- **Pas de nouveau financement** – Il arrive parfois que les gouvernements exigent qu'une initiative d'intégration soit mise en œuvre grâce au réaligement de fonds existants. Un nouveau financement n'est pas fourni. Cela peut forcer à trouver des solutions créatives comme la ventilation d'une stratégie de développement en segments plus petits et plus réalisables, dont on peut rendre compte des résultats chaque année.

Toutefois, malgré ces difficultés, il existe au Canada de bons modèles fonctionnels de services sociaux et/ou de santé intégrés. Les modèles les mieux développés et qui sont en existence depuis le plus de temps sont peut-être les CLSC du Québec.

7.2 Les CLSC du Québec

Ces trente dernières années, en particulier au Québec, certains efforts majeurs faits pour améliorer la santé des populations locales ont abouti grâce à l'utilisation des centres de santé communautaires qui intègrent les services de soins préventifs et primaires avec les services sociaux. Au Québec, on les appelle des CLSC (centres locaux de services communautaires). Il s'agit de cliniques communautaires qui sont gérées et financées par le gouvernement provincial. Ce réseau offre une grande variété de services, notamment des soins de santé primaires, des services préventifs de santé, du counseling psychologique, des services de soutien comme des ressources et des subventions pour le logement, et de développement communautaire. Le CLSC a pour mission d'utiliser une approche communautaire, multidisciplinaire et globale pour améliorer l'état de santé et le bien-être des membres de la communauté. De plus, l'un de ses objectifs est d'inciter les individus et ceux qui leur sont proches à prendre en charge leurs propres santé et bien-être. On compte 147 CLSC répartis à grandeur de la province.

Ces dernières années, les CLSC ne sont plus des organismes indépendants; ils ont fusionné avec les CSSS (Centres de santé et de services sociaux) qui sont les organisations locales de services sociaux et de santé prédominantes qui supervisent également tous les services sociaux et services liés à la santé dans une communauté, y compris les maisons de soins infirmiers et les hôpitaux. À Montréal et dans l'Outaouais, les services de santé sont fournis par les (CSSS), organismes similaires aux CLSC, mais qui intègrent en plus, dans le modèle, des services hospitaliers de soins actifs, des services de soins de longue durée et de réadaptation. On peut avoir accès à tous les services dans la région de Montréal en plaçant un seul appel au to 8-1-1, et on sera orienté vers la bonne ressource.

Le site Web du CSSS de Montréal (www.santemontreal.qc.ca) indique que les CSSS ont été créés pour répondre aux défis de l'approche populationnelle qui aborde la gestion de la santé en suivant une approche plus proactive et qui contribue à maintenir et à améliorer la santé des

citoyens. C'est à eux qu'a été confiée la responsabilité de définir le projet clinique et organisationnel.

D'après le CSSS de Montréal, pour créer un véritable réseau local axé sur la responsabilité populationnelle, le CSSS doit mobiliser les acteurs du réseau et de la communauté pour franchir une série d'étapes que nous pourrions définir de la façon suivante :

- Établir le portrait de santé de la population du territoire en tenant compte du profil sociodémographique des clientèles et de la population, du profil sanitaire, c'est-à-dire des facteurs déterminants de la santé et des tendances sociodémographiques et environnementales du profil d'utilisation des services.
- Définir les priorités qui reflètent la vision locale des besoins. Afin d'identifier clairement les résultats attendus, il faudra s'assurer de la participation des acteurs du réseau sociosanitaire et des autres ressources du territoire. Il importe au premier chef que la population soit partie prenante du projet.
- Identifier les interventions efficaces tant sur le plan clinique qu'organisationnel. Leur efficacité quant à l'amélioration de la santé et du bien-être de la population doit avoir été démontrée.

7.3 Centres de santé communautaires du Canada anglais

Les centres de santé communautaires dans le Canada anglais sont des organismes sans but lucratif gérés par la communauté qui intègrent les services de soins de santé primaires, de promotion de la santé et de développement communautaire, en faisant appel à des équipes multidisciplinaires de fournisseurs de services de santé. Ces équipes incluent souvent, entre autres, des médecins, des infirmiers praticiens, des diététiciens, des promoteurs de la santé, des conseillers qui reçoivent un salaire, au lieu d'un paiement à l'acte. Les centres de santé communautaires sont parrainés et gérés par des conseils communautaires sans but lucratif auxquels siègent des membres de la communauté et autres personnes qui fournissent des services sociaux et de santé.

Les services sont conçus pour répondre aux besoins particuliers d'une communauté définie. De plus, les CSC fournissent divers services de prévention de la maladie et de promotion de la santé qui visent à sensibiliser aux déterminants de la santé plus généraux tels que l'emploi, l'éducation, l'environnement, l'isolement et la pauvreté. Les CSC sont en existence au Canada depuis les années 1920; on en compte aujourd'hui plus de 300 dans tout le Canada, 55 se trouvant en Ontario.

Cette approche de la santé communautaire englobe les facteurs généraux qui déterminent la santé comme l'éducation, l'emploi, le revenu, le soutien social, l'environnement et le logement. Voici certains services qu'offrent habituellement les CSC :

- **Soins primaires** - Évaluation de santé, prévention de la maladie, interventions en cas de maladie aiguë et épisodique ou de blessures; soins génésiques primaires, détection précoce et traitement initial et continu des maladies chroniques; éducation et soutien pour l'autogestion de la santé; soutien pour les soins hospitaliers, les soins à domicile et les soins en établissements de longue durée; dispositions pour un service 24 heures par jour sept jours par semaine; coordination des services et aiguillage; rappel actif et tenue d'un dossier médical

complet (souvent électronique) pour chaque client dans le centre; soins de santé mentale primaires, y compris des services de counseling psychosocial; coordination et accès à la réadaptation; soutien des malades en phase terminale.

- **Promotion de la santé et renforcement des capacités communautaires** – Cessation de fumer; promotion de la santé dans le cas de l'asthme; ateliers sur la nutrition; éducation sur le diabète; sécurité du logement et sans-abrisme; sécurité alimentaire; accès à l'emploi; soutien aux immigrants et aux réfugiés notamment préparation à l'ALS; groupe de soutien parental; sécurité des fermes; soutien de l'allaitement; préparation à l'accouchement; halte-accueil et centre de loisirs pour personnes âgées; gestion de la colère et du stress; counseling en matière d'estime de soi; prévention de la violence; règlement des conflits judiciaires communautaires; cuisine, jardins communautaires; programmes multilingues sur divers sujets; programmes pour les jeunes; groupe de soutien des femmes; programmes de collations scolaires (Association of Community Health Centres, 2009).

Une étude récemment menée en Ontario a trouvé que les soins de santé pour les personnes atteintes d'une maladie chronique, en particulier le diabète, étaient plus efficaces lorsqu'ils étaient fournis dans des CSC que dans les cabinets de médecin traditionnels, ce qui était surtout dû au réseau d'équipes multidisciplinaires. L'Observateur-Q de 2008 du Conseil ontarien de la qualité des services de santé a trouvé que les CSC obtiennent un meilleur taux de satisfaction qu'un médecin et autre organisme de santé dans le cas du traitement des maladies chroniques, en particulier le diabète, mais également avec des groupes de la population qui se heurtent généralement à de plus grands obstacles à la santé et aux soins de santé à cause de la pauvreté, de logements inhabitables, de la langue, de l'isolement géographique et d'autres facteurs; [le CSC] « ne se concentre pas uniquement sur les soins de santé. Ses activités sont fondées sur le principe qu'une diversité de facteurs, dont le logement, l'emploi, les relations sociales, le revenu, ainsi que la biologie, le sexe et la race - que nous appellerons déterminants de la santé – sont autant d'éléments qui conditionnent l'état de santé des personnes » (Rapport annuel du COQSS, 2008).

Les CSC sont des modèles très prometteurs, mais dans leurs 30 années d'existence au Canada, ils n'ont pas recueilli un grand soutien. Cela est principalement dû à certains obstacles vus plus haut. De plus, les modèles de financement, en particulier le salaire pour les médecins, se sont heurtés à l'opposition de groupes de médecins, comme cela a été le cas pour le partage du contrôle entre diverses professions de la santé au lieu du contrôle hiérarchique traditionnel. De nouvelles générations de médecins montrent moins de résistance envers le modèle de santé communautaire et les postes salariés, et de nombreux gouvernements provinciaux encouragent la création de CSC et/ou de réseaux d'omnipraticiens (sortes de CSC virtuels) dans le cadre de la réforme des soins primaires.

7.4 Intégration des services sociaux en Saskatchewan

À part les CLSC et les Centres de santé communautaires, il semble y avoir eu étonnamment peu de tentatives systématiques d'intégration d'autres services sociaux au Canada. Lorsque des modèles existent, ceux-ci sont soit partiels (p. ex. au Québec, les services de santé et services sociaux sont intégrés et au Manitoba plusieurs services sont

axés sur les enfants), soit principalement locaux (p. ex. quelques centres multiservices en Ontario). La Saskatchewan est la seule province qui semble avoir fait l'effort méthodique de mieux intégrer un large groupe représentatif de services sociaux au niveau provincial et au niveau régional.

La Saskatchewan a adopté une approche de prestation des services sociaux intégrée depuis 1989, et elle est l'une des premières administrations à avoir adopté cette approche. L'intégration des services est coordonnée par l'entremise de deux structures organisationnelles : le Human Service Integration Forum (HSIF) et les dix comités intersectoriels régionaux (CIR).

- Le Human Services Integration Forum se compose de sous-ministres associés/adjoins des ministères provinciaux qui fournissent des services sociaux, notamment les ministères de l'Éducation, de la Justice et du Procureur général; de la Santé; des Services sociaux; des Relations avec les Métis et les Premières nations; du Tourisme, des Parcs, de la Culture, du Sport, et des Services correctionnels, de la Sécurité publique et des Services de police. Le Human Services Integration Forum assure la coordination des initiatives de services sociaux au niveau de la haute direction. Un directeur exécutif soutient le Human Services Integration Forum et les comités intersectoriels régionaux et coordonne la planification stratégique pour l'intégration des services en Saskatchewan.
- Chacun des dix CIR couvre un secteur précis de la province. Chacun d'eux a un effectif particulier qui inclut des représentants des ministères provinciaux et fédéraux, des écoles, de la police, des organisations des Premières nations et des Métis, et autres organismes locaux offrant des services sociaux, y compris des organisations communautaires. Les CIR sont chargés de coordonner les services sociaux au niveau régional et de renforcer la capacité communautaire. Chaque CIR bénéficie de l'aide d'un coordonnateur qui est financé par le gouvernement provincial²⁵.

Récemment, on a accordé une attention particulière au renouvellement, à la revitalisation et à la redynamisation des services intégrés en Saskatchewan. Ce renouvellement de l'intégration des services sociaux marque le début de la seconde génération d'intégration des services dans cette province. Par contraste, la plupart des initiatives d'intégration en cours dans d'autres administrations en sont au premier stade de production.

Un exemple d'intégration des services est le Community Services Village à Regina qui est centré dans une banque alimentaire qui réunit 20 organismes et fournit des services aux personnes qui vivent dans la pauvreté. Les coûts d'infrastructure requis pour avoir une installation aussi spacieuse ont été élevés. Mais les clients trouvent l'installation très pratique et il est bien plus facile pour les organismes de travailler ensemble.

7.5 Enfants en santé Manitoba

En 1999, le gouvernement du Manitoba s'est engagé à faire du développement de la petite enfance une priorité à l'échelle gouvernementale. L'année suivante, il a créé

²⁵ Fondé largement sur Thompson, 2007

Enfants en santé Manitoba (ESM) et établi le Comité du Conseil exécutif pour enfants en santé, premier et seul comité interministériel permanent au Canada voué au bien-être des enfants et des adolescents. Ce comité comprend les ministres de huit ministères (Vie saine; Santé; Affaires autochtones et du Nord; Justice; Culture, Patrimoine et Tourisme; Travail et Immigration; Éducation, Citoyenneté et Jeunesse; Services à la famille et Logement). Ces huit partenaires gouvernementaux se partagent la responsabilité d'élaborer, de coordonner et de mettre en œuvre la politique publique axée sur les enfants du Manitoba, et l'objectif de voir à ce que tous les enfants du Manitoba atteignent leur plein épanouissement.

Ce comité du Conseil exécutif bénéficie de l'aide d'un comité de sous-ministres ainsi que d'Enfants en santé Manitoba qui, non seulement est responsable de l'élaboration des politiques, du développement communautaire et de l'évaluation des programmes, mais sert également de personnel et de secrétariat aux deux comités gouvernementaux.

Tandis que le Comité du Conseil exécutif maintient son engagement politique et sa vision, le programme s'appuie également sur un fort engagement et leadership communautaires. Dans l'ensemble de la province, 26 coalitions axées sur les parents et les enfants décident collectivement quels services et mécanismes de soutien seront mieux en mesure de répondre aux besoins des familles dans ce secteur particulier. Cette approche axée sur le développement communautaire réunit les parents, les divisions scolaires, les éducateurs de la petite enfance, les professionnels de la santé et autres organismes communautaires dans le cadre des coalitions communautaires et régionales pour promouvoir un rôle parental positif, améliorer la nutrition et la santé physique des enfants, promouvoir l'alphabétisation et l'apprentissage, et renforcer la capacité communautaire.

Les objectifs d'Enfants en santé Manitoba consistent à :

- chercher, développer, financer et évaluer des initiatives innovatrices et des stratégies à long terme visant à améliorer les possibilités de réussite des enfants du Manitoba;
- coordonner et intégrer les politiques, les programmes et les services dans l'ensemble du gouvernement pour les enfants, les jeunes et les familles, à l'aide de modèles d'intervention précoce et de santé de la population;
- augmenter la participation des familles, du voisinage et de la communauté dans les services de prévention et de développement de la petite enfance (DPE) par le biais du développement communautaire;
- faciliter le développement de la politique publique axée sur l'enfant et l'échange de connaissances entre départements et secteurs, au moyen d'évaluation et de recherche sur les déterminants clés et les résultats pour le bien-être des enfants.

Selon un résumé positif paru dans un article de 2006 (Conseil canadien de la santé 2006), le résultat a été un ensemble complexe de services publics qui soutiennent les enfants et les familles, notamment :

- une allocation prénatale pour aider les femmes à faibles revenus à acheter des aliments nutritifs durant leur grossesse;

- un programme d'encadrement en vue de mettre fin au SAF (syndrome d'alcoolisation fœtale) qui cible les femmes à risque d'avoir un enfant atteint de ce syndrome;
- un programme de dépistage systématique qui cible 90 pour cent des nouveau-nés et leurs parents et apporte du soutien aux familles, par exemple, au moyen de visites à domicile dans le cadre du programme Les familles d'abord, et en fournissant aux parents des renseignements sur les programmes de formation au rôle de parent dans leur communauté;
- le Tripe P – Programme de formation au rôle de parent positif, programme de renommée internationale reconnu pour sa capacité à accroître les compétences des parents et à réduire les problèmes de comportement;
- les programmes de développement de la petite enfance, notamment le populaire programme Soupe à l'alphabet qui combine une alimentation saine aux activités de lecture et de langage entre parents et enfants et qui favorise l'acquisition de capacités de lecture et d'écriture, tout en aidant les parents à découvrir des produits nutritifs à prix abordable. Le programme Soupe à l'alphabet emploie les parents de la communauté comme bénévoles et facilitateurs dans le cadre du renforcement des capacités communautaires.

D'autres activités d'ESM menées ces dernières années incluent :

- l'amélioration des services de soins primaires pour les adolescents au moyen de l'expansion des cliniques pour adolescents dans la province.
- La collaboration avec les ministères partenaires pour élaborer une stratégie de prévention du syndrome d'alcoolisation fœtale.
- Le renforcement des relations avec les ministères fédéraux au niveau régional, notamment l'Agence de la santé publique du Canada (ASPC) et la Direction générale de la santé des Premières nations et des Inuits (DGSPNI);
- Promouvoir la stratégie provinciale d'évaluation et de recherche concernant Enfants en santé Manitoba. L'évaluation du projet inclut de travailler avec les 38 divisions de la province pour évaluer la préparation des enfants à l'école maternelle, en examinant leur santé physique et leur maturité développementale, sociale et émotionnelle durant chaque année que passe l'enfant à la maternelle. D'autres stratégies d'évaluation à long terme sont en cours d'élaboration, utilisant l'Enquête longitudinale nationale sur les enfants et les jeunes (ELNEJ), ainsi qu'une étude longitudinale propre au Manitoba sur le modèle de l'ELNEJ.

Bien que l'on commence à peine à voir les résultats de cet engagement intégré à long terme, il semble que l'engagement politique se soit maintenu, et il ne nous reste plus qu'à surveiller le programme Enfants en santé Manitoba pour voir ses effets sur l'état de santé des enfants du Manitoba²⁶.

²⁶ Sources : Sale (2003), site du Gouvernement du Manitoba (2007) et d'Enfants en santé Manitoba, www.gov.mb.ca/healthychild/

7.6 Une vision de services de développement humain et de santé intégrés

Bien qu'il existe un nombre de modèles d'intégration des services sociaux et/ou de santé potentiellement utiles, il semble ne pas y avoir de vision quant à ce que ce système pourrait être dans l'avenir. L'effort d'élaborer cette vision a été fait dans le cadre du travail d'une équipe qui créait la conception d'une nouvelle communauté – Seaton – qu'avait planifiée le gouvernement de l'Ontario dans les années 1990. À la fin, cette communauté n'a pas été construite, mais dans le cadre de sa conception globale (qui a occupé le troisième rang dans le concours de conception), le groupe communautaire du consortium CEED²⁷ a élaboré une stratégie de développement humain globale²⁸.

Cette stratégie était fondée sur trois principes fondamentaux, les suivant par ordre de priorité :

- Renforcer la communauté : bâtir une communauté tolérante, solidaire, forte déterminée à assurer le bien-être de ses membres – présents et futurs – et la protection et l'amélioration de son environnement;
- Promouvoir le bien-être et éviter les problèmes : mettre l'accent sur la promotion du bien-être, la prévention des problèmes et la mobilisation de la capacité d'effort individuel, d'entraide et de soutien mutuel de la communauté;
- Répondre aux besoins et fournir des services : fournir un éventail complet de services sociaux dans un système intégré qui est mis au point à partir du niveau du ménage et fait partie intégrante de la communauté et des communautés de Pickering et de Durham dont Seaton fait partie.

La stratégie comportait deux principaux volets, qui étaient complémentaires :

- mettre l'accent sur la création d'une forte culture communautaire, la promotion du bien-être et la prévention des problèmes en amont de la prestation des services;
- construire à partir du niveau du ménage.

Les principaux éléments du volet promotion/prévention de la stratégie culturelle, sociale et de développement humain globale étaient :

1. Répondre aux besoins de tous
2. Élever des enfants en santé
3. Faire du travail une source de bien-être
4. Assurer un vieillissement sain
5. Stimuler la créativité et l'innovation
6. Créer un sentiment d'appartenance à la communauté

²⁷ Community, Environment, Economy, Design

²⁸ Le bien-être/développement humain n'était que l'un des sept éléments considérés dans la conception du Consortium CEED relative à Seaton: les autres étaient la gouvernance, la santé de l'écosystème, la vitalité économique, le développement durable, la qualité environnementale et l'équité sociale.

7. Assurer la sécurité
8. Permettre aux gens de se responsabiliser
9. Fournir des services sociaux de promotion et de prévention

Le concept de créer à partir du niveau du ménage s'appliquait, non seulement au système de service sociaux, mais il a été, en fait, appliqué à la conception globale de toute la communauté. On a reconnu qu'en concevant les services sociaux à partir du ménage, de l'îlot et du quartier, il aurait fallu prêter attention aux besoins en services sociaux des individus et à la nécessité d'avoir des locaux et des installations pour répondre à ces besoins. Au titre de l'efficacité et de la création d'un sentiment d'appartenance à la communauté, des installations à usage multiple gérées au niveau de l'îlot, du quartier et du village ont été proposées. Le tableau 1, qui explore quelles installations pourraient être nécessaires à chaque niveau pour deux aspects du développement humain, l'apprentissage et les services communautaires, donne un exemple de la portée de cette conception. On trouvera chez Hancock, 1999, une description détaillée des services de santé fondés sur ce modèle.

Tableau 1 : Certaines répercussions des services sociaux sélectionnés, selon le niveau de conception, proposition de CEED pour le concours relatif à la conception de Seaton, 1994

<u>Niveau de conception</u>	<u>Centre d'apprentissage</u>	<u>Centre de services communautaires</u>
Ménage	<ul style="list-style-type: none"> • Terminal vidéo interactif relié au centre de ressources et d'information communautaires et au réseau d'apprentissage électronique de Seaton. 	<ul style="list-style-type: none"> • Accès en ligne aux CSC du quartier, du village et de la ville pour recevoir des conseils et du soutien. • Accès en ligne au Self-Help Clearing House et à son logiciel d'auto-assistance et de soins personnels. • Système d'alarme câblé résidentiel (feu/fumée, aide des personnes âgées, vol).
Îlot urbain	<ul style="list-style-type: none"> • Salles réservées aux ressources et à l'apprentissage en ligne dans de grands îlots urbains (p. ex. unités multiples). • Espaces communs pour le jeu, les loisirs, l'artisanat et autres utilisations. 	<ul style="list-style-type: none"> • Salles réservées aux services communautaires dans de larges îlots pour les travailleurs des services sociaux rendant visite.
Quartier	<ul style="list-style-type: none"> • École communautaire élémentaire comme centre d'apprentissage continu, avec des installations 	<ul style="list-style-type: none"> • Logement pour les personnes ayant des besoins spéciaux.

	culturelles et pour la détente, y compris un centre de ressources et d'information communautaires.	
Village	<ul style="list-style-type: none"> • École secondaire communautaire avec des installations communautaires pour l'apprentissage continu et les loisirs, y compris des espaces pour l'artisanat, les violons d'Ingres, des espaces pour la piscine, le gymnase, les arts et la culture, la bibliothèque, etc. 	
Ville	<ul style="list-style-type: none"> • Collège écocommunautaire, collège communautaire, secteur d'attache pour le réseau d'apprentissage électronique de Seaton, principales installations culturelles, y compris un espace pour les spectacles, un musée ou une galerie, etc. 	

8. Vers une approche nationale axée sur le soutien de l'action locale au profit de la santé de la population et du développement humain.

Bien que le gouvernement fédéral ait sans aucun doute un rôle à jouer dans le soutien des nouveaux processus de gouvernance communautaire et des nouvelles structures nécessaires pour renforcer la résilience de la communauté et celle de ses membres, et dans le renforcement des capacités individuelles et communautaires (et s'appuie sur ces capacités), il est important de reconnaître le rôle vital que doivent aussi jouer les gouvernements provinciaux. Il y a deux importantes raisons à cela : la première est que les gouvernements municipaux sont établis par les gouvernements provinciaux, et la seconde, comme le note Torjman (2007) :

«de nombreux domaines de fond sur lesquels porte ce programme [communautaire] – logement décent abordable, alphabétisation et formation et emploi [et, pourrait-on ajouter, éducation et services de santé] relèvent principalement de la compétence provinciale ».

Bien entendu, les administrations municipales jouent également un rôle dans les domaines qui touchent à la santé et au développement humain, notamment l'aménagement des terres, le transport, la gestion des déchets, les parcs et loisirs, les services sociaux, le logement social et autres.

Dans un chapitre intitulé « Creating an enabling environment », Torjman (2007) examine le nouveau rôle des gouvernements fédéral et provinciaux et des autres bailleurs de fonds (philanthropiques) dans le renforcement de la gouvernance communautaire, le soutien des communautés et la création des conditions qui permettent aux communautés de renforcer leur résilience et celle de leurs citoyens, au-delà de leur rôle, en investissant directement dans les services, les programmes et les installations dans les communautés.

Commentaires d'intervenants clés sur les modèles universels

[Traduction] « Je ne crois pas que l'on puisse transposer un modèle d'un endroit à un autre [...] Je suis convaincu qu'il n'existe pas de modèle universel ».

« Je crois que l'une des choses que nous reconnaissons aujourd'hui est que plutôt que de parler des modèles, nous parlons plus des principes ».

Torjman décrit ce nouveau rôle comme celui de « facilitateurs » de processus communautaires complexes » et indique que cela exige que ces bailleurs de fonds permettent de savoir, d'agir et d'examiner, c'est-à-dire, de développer la base de données, d'établir des liens axés sur la collaboration et d'examiner les progrès accomplis (p. 244). Elle offre des idées quant à la façon de le faire :

- « Permettent de savoir » consiste à échanger avec la communauté l'information détenue par les gouvernements (c.-à-d. le Community Accounts Project a débuté à Terre-Neuve-et-Labrador et il est aujourd'hui reproduit dans d'autres provinces); en soutenant la recherche communautaire menée sous l'impulsion de la communauté ainsi que la collecte et l'analyse de l'information; en établissant des liens entre les communautés et les chercheurs (p. ex. programme Alliances de recherche universités-communautés du CRSH); et en mettant en commun des connaissances et de l'expérience des communautés. (Il est utile ici de rappeler ce qu'a souvent répété John McKnight, à savoir que les institutions apprennent des études, mais les communautés apprennent des cas concrets.)
- « Permettent d'agir » en encourageant les processus de gouvernance communautaire qui travaillent en collaboration pour aborder les problèmes complexes; en investissant du « capital de patience » dans ce processus à long terme; en participant activement et en échangeant l'information sur les pratiques exemplaires du pays entier; et en établissant des modèles de coordination et de collaboration dans leur propre travail, en travaillant de façon horizontale et en adoptant une approche pangouvernementale.
- « Permettent d'examiner » en encourageant l'apprentissage au sein des communautés et entre les communautés, notamment la pratique réflexive, l'aide en terme de comportement et le développement des compétences.

Il est d'une suprême importance de reconnaître qu'il n'existe pas de modèle universel pour renforcer les capacités communautaires (et s'appuyer sur ces capacités) et pour améliorer la santé et le développement humain qui puisse s'appliquer à toutes les communautés. Chaque communauté est différente par son histoire, les problèmes auxquels elle est confrontée, les ressources qu'elle réussit à mobiliser, et les relations déjà

présentes en son sein et les relations entre elle et d'autres ordres supérieurs de gouvernement.

Néanmoins, en nous fondant sur les ouvrages que nous avons consultés pour le présent rapport, sur les points de vue des principaux intervenants, et sur ma propre expérience acquise dans le cadre de mon travail sur les villes et les communautés en bonne santé, nous pouvons faire les observations suivantes.

1. De nombreux déterminants de la santé ont des effets au niveau communautaire, dans les milieux environnants – maisons, écoles, lieux de travail, quartiers – là où les gens vivent, apprennent, travaillent et se divertissent.
2. Les communautés – même les plus défavorisées et qui ont à relever les plus gros défis, comme la communauté crie d'Oujé-Bougoumou que nous avons décrite plus haut, ont des forces, des capacités et des actifs importants, parfois étonnants, que la communauté peut mettre à profit pour aborder ses problèmes et pour améliorer sa santé, son bien-être et son niveau de développement humain.
3. Les gouvernements fédéral et provinciaux, les organismes philanthropiques et le secteur privé feraient bien de reconnaître les forces présentes dans les communautés, de s'appuyer sur la capacité communautaire et de la renforcer en investissant dans le développement communautaire reposant sur les actifs.
4. L'adoption d'une telle stratégie exige, entre autres :
 - a. de reconnaître le rôle vital que jouent les administrations municipales dans la création des conditions favorables à la bonne santé et au développement humain, en en faisant de principaux partenaires, et en renforçant leurs pouvoirs (y compris, le pouvoir de taxation);
 - b. d'adopter une approche pangouvernementale aux questions liées à la santé de la population et au développement humain à laquelle participent tous les ordres de gouvernement, allant du gouvernement fédéral au gouvernement local;
 - c. d'encourager et soutenir les processus et structures de gouvernance communautaire qui permettent aux nombreux intervenants de la communauté – secteurs public, privé, sans but lucratif et communautaire, ainsi qu'à chaque citoyen – de reconnaître et de définir les problèmes communautaires locaux et les solutions et d'élaborer des stratégies à long terme reposant sur les actifs pour les aborder.
5. Pour cela, il faut que les gouvernements et les organismes philanthropiques s'engagent à financer à long terme cette infrastructure de gouvernance communautaire. Cela veut dire plus précisément qu'ils doivent fournir moins de financement à court terme étroitement ciblé et plus de financement général à long terme que les communautés peuvent utiliser de la façon qu'elles jugent nécessaire pour renforcer la capacité communautaire dont elles ont besoin.
6. Tant au niveau national que provincial, il est nécessaire d'établir des organismes nationaux et/ou provinciaux (ou lorsqu'ils existent déjà, de les renforcer fortement) pouvant favoriser la création d'écoles, de lieux de travail et de

communautés en bonne santé. Ces organismes faciliteraient et aideraient la création d'infrastructures de gouvernance communautaire, mèneraient des recherches, mettraient en commun leurs connaissances et leur expérience, élaboreraient des outils et « formeraient les formateurs ».

7. Tout effort au niveau national pour améliorer la santé de la population et le développement humain sain afin de créer des communautés plus saines doit s'accompagner d'un effort national d'élaborer de nouvelles mesures de progrès comme celles dont nous avons parlé ci-dessus de sorte que l'on puisse voir les progrès que nous avons réalisés dans l'atteinte de ces vastes objectifs sociétaux. Ces nouvelles mesures doivent pouvoir s'appliquer à tous les niveaux, de l'international au local, et elles doivent être élaborées en partenariat avec les communautés, dans le cadre du renforcement de la capacité de la communauté de se comprendre et de comprendre sa situation, condition préalable nécessaire pour poser des gestes concrets.
8. Les gouvernements devraient mettre en place des systèmes de services de développement humain mieux intégrés comme élément du renforcement de la capacité communautaire (ou comme élément d'appui sur cette capacité). Dans les communautés défavorisées, en particulier, ces services devraient être situés près des personnes qui les utilisent ou qui en ont besoin; ils devraient être faciles à trouver (« accessibles à partir d'un même point ») et à utiliser et, le cas échéant, être logés dans une seule installation qui maximise l'utilisation de l'espace commun pendant la journée.

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Annexe 1 : Villes et communautés en bonne santé - hier²⁹

« [...] la plus grande contribution à la santé de la nation ces 150 dernières années est le fait non pas des médecins ni des hôpitaux, mais de l'administration locale ».

--Dr Jessie Parfitt, dans *The Health of a City : Oxford, 1770-1974*

L'histoire nous enseigne pourquoi il est utile de s'occuper de la santé de la population au niveau communautaire. Comme l'a relevé Dr Thomas McKeown dans son ouvrage fameux publié dans les années 1970 (McKeown, 1978), les gains les plus importants en matière d'espérance de vie et de santé humaines ces 200 dernières années sont attribuables à l'accès à l'eau potable, à de meilleurs réseaux d'assainissement, à une meilleure alimentation et à l'amélioration du niveau de vie – tous se produisant au niveau communautaire, et aucun d'eux n'étant le résultat de meilleurs services de santé per se.

En fait, les efforts faits pour améliorer la santé des villes et de leurs citoyens remontent au moins à l'époque d'Hippocrate, médecin grec considéré comme le « père de la médecine », qui fut le premier à observer que la maladie était souvent liée à des facteurs tels que le régime alimentaire, la forme physique, et l'environnement dans lequel on vit (Hippocrates, 400 av. J.-C.). La Renaissance italienne, qui a subi des vagues successives de peste, a reconnu le lien entre la maladie et le cadre de vie. Des conseils sanitaires, appelés magistratures spéciales, ont été établis dans les villes, et ils combinaient les pouvoirs législatifs, judiciaires et exécutifs dans la ville ou la région. Ils exerçaient le pouvoir sur toutes les affaires touchant la santé de la population, qu'il s'agisse du système alimentaire, des travaux publics comme le réseau d'alimentation en eau, les égouts et les déchets, de la prestation de services, et de la réglementation des activités économiques comme l'hôtellerie et la prostitution. (Cipolla, 1976).

Au XIX^e siècle, les villes européennes (surtout britanniques) et d'Amérique du Nord ont connu de graves problèmes de santé, conséquences de la révolution industrielle, dus en particulier au surpeuplement, à la malnutrition, aux mauvaises conditions de logement ou à des conditions insalubres, à des réseaux d'alimentation en eau, d'assainissement, d'enlèvement des déchets et de contrôle de la pollution atmosphérique inadéquats. Il en a résulté un idéal sanitaire et le mouvement de la santé publique, initialement limité à l'Angleterre victorienne s'est ensuite répandu dans tous les pays en voie d'industrialisation de l'Europe et de l'Amérique du Nord. Les villes sont devenues le principal centre d'intérêt des services de santé publique, allant de l'établissement de la Health in Towns Commission en Grande-Bretagne en 1843, à la description « d'Hygeia » par Sir Benjamin Ward Richardson en 1875, vision détaillée et exhaustive d'une « cité de la santé » dans un avenir idéalisé.

Au Canada, la Commission de la conservation, créée par le gouvernement canadien en 1909, comportait un comité de la santé publique qui examinait la question de l'urbanisme parce qu'il avait constaté que cette question englobait la conservation des ressources naturelles et la conservation des ressources vitales (protection de la santé des gens). Leurs travaux ont été présentés à une conférence nationale en 1913, et ils ont retenu les services de Thomas Adams, éminent urbaniste du Royaume-Uni. Ce dernier, à titre de conseiller en urbanisme de la Commission a, de 1914 à 1919, révisé le projet de loi type sur

²⁹ Selon Hancock, 1990

l'urbanisation de la Commission, s'est chargé de préparer les projets de loi sur l'urbanisation de la plupart des provinces, a rédigé un document précurseur sur l'aménagement de l'espace rural, consulté près de quarante conseils locaux, écrit pour un bulletin trimestriel *Conservation of Life* édité par la Commission, aidé à organiser la Civic Improvement League, et en 1919 il a été élu le tout premier président de l'Institut d'urbanisme du Canada. Parallèlement, à Toronto, inspiré par les mêmes idéaux, Charles Hastings, responsable du service de santé publique de 1910 à 1929, a fait de cette ville la « plus saine des grandes villes » du monde (*MacLean's Magazine*, juillet 1919) et le service de santé publique a atteint une renommée internationale.

Aux États-Unis, un mouvement de villes en santé similaire prenait forme. L'Inter-Chamber Health Conservation Contest a été établi en 1929 par la Chambre de commerce américaine en partenariat avec l'American Public Health Association, la National Association of Life Underwriters, et le service de santé publique américain. Dans le cadre de ce concours, les villes étaient classées en fonction des mesures sanitaires, de la prévention des maladies, de la promotion de la santé, du soutien financier pour le travail dans le domaine de la santé, et les taux de mortalité. Le but était double : premièrement, faire connaître aux citoyens, en particulier aux gens d'affaires, l'organisme de santé local et les problèmes de santé de la communauté en vue d'apporter des améliorations et de réaliser un gain économique; deuxièmement, réduire l'incidence de maladies évitables et, au bout du compte, le décès (Gold, 1930). Pendant six années consécutives, entre 1929 et 1935, la ville de Milwaukee au Wisconsin - qui selon *MacLean's Magazine* s'est classée au deuxième rang, après Toronto - a remporté la première ou deuxième place au concours dans la catégorie de la plus grande ville (population, plus de 500 000 habitants).

Nous pouvons donc voir que la santé des villes a été un objet de préoccupation nationale et internationale pendant près d'un siècle. Cette leçon de l'histoire nous enseigne, comme l'a observé Jessie Parfitt qu'en fait, « la plus grande contribution à la santé de la nation ces 150 dernières années est le fait non pas des médecins ni des hôpitaux, mais de l'administration locale ».

Malheureusement, avec l'avènement de la médecine moderne dans les années 1930, lorsque les premiers antibiotiques sont devenus disponibles, et avec l'avènement de soins médicaux et chirurgicaux d'une grande efficacité qui a suivi la Seconde Guerre mondiale, l'importance de la santé publique s'est affaiblie, et les leçons durement apprises ont été mises de côté, voire oubliées. Ce n'est pas avant le Rapport Lalonde en 1974 qui distinguait quatre groupes de facteurs influant sur la santé - l'un d'eux étant l'organisation des services de santé - et indiquait que l'amélioration de l'état de santé dépendait surtout de l'amélioration du mode de vie et de l'environnement - que la situation a commencé à changer à nouveau d'orientation, avec la réapparition du mouvement des villes et des communautés en santé contemporain.

Annexe 2 : Villes-santé/communautés-santé - aujourd'hui

Le mouvement mondial contemporain des villes-santé/communautés-santé est né au Canada, lors d'une conférence tenue en 1984 pour célébrer le centenaire du conseil de la santé local et le 150^e anniversaire de la Ville de Toronto. Cette conférence intitulée « Au-delà des soins de santé » (Hancock, 1985) était la première à explorer le concept de « politique publique saine » et elle était accompagnée d'un atelier d'une journée – « Toronto - santé 2000 ». Elle avait pour but de visualiser une ville future dans le cadre de l'objectif du ministère de la Santé publique de faire de nouveau de Toronto « la ville la plus saine de l'Amérique du Nord ». Le conférencier principal était Len Duhl, inventeur du concept de la communauté-santé dans les années 1960 et professeur de santé publique à l'Université de Berkeley en Californie.

L'idée d'une « ville-santé » a été reprise par Ilona Kickbusch qui participait à la conférence et qui était alors responsable de la promotion de la santé au bureau régional de l'OMS pour l'Europe. Elle a vu dans le concept de ville-santé la possibilité de faire la promotion de la santé, alors en cours d'élaboration au bureau régional de l'OMS pour l'Europe, dans les rues des villes d'Europe, d'en prendre les concepts globaux pour les appliquer au niveau local de façon concrète.

En janvier 1986, un petit groupe de promoteurs de la santé convoqué par Kickbusch s'est réuni au bureau régional de l'OMS pour l'Europe à Copenhague pour planifier un projet de villes-santé. Ce groupe de planification prévoyait que son projet pourrait susciter l'intérêt de six à huit villes. Toutefois, ce projet qui a débuté par un symposium sur les villes-santé à Lisbonne en avril 1986 a attiré la participation de 56 représentants de 21 villes et de 17 pays. Onze villes ont été sélectionnées pour le projet de l'OMS en 1986, mais la popularité du projet était telle que 14 autres villes ont été sélectionnées en 1988, et en 1991, on en comptait 35.

Aujourd'hui, il y a des réseaux de villes-santé dans les six régions de l'OMS qui comptent au total 1200 villes dans plus de 30 pays de la région de l'Europe de l'OMS; ces villes sont reliées dans le cadre de réseaux nationaux, régionaux, métropolitains et thématiques. Dans la région panaméricaine, le projet est connu sous le nom de « communautés-santé » et il compte des centaines de municipalités de nombreux pays, en particulier du Brésil et du Mexique. Il y a également un réseau villes-santé très solide dans la Région de l'Asie du Sud-Est, un réseau de « villages-santé » dans la région de la Méditerranée orientale, un petit réseau villes-santé dans la Région africaine et un réseau « îles-santé » dans la Région du Pacifique occidental.

Le programme Villes-Santé du bureau régional de l'OMS pour l'Europe incite les gouvernements locaux à participer au développement de la santé par l'intermédiaire d'un processus d'engagement politique, de changement institutionnel, de renforcement des capacités, de planification dans le cadre de partenariats et de projets innovateurs. Il favorise une planification et une politique méthodiques et exhaustives en accordant une importance particulière aux inégalités et à la pauvreté urbaine, aux besoins des groupes vulnérables, à la gouvernance participative et aux déterminants sociaux, économiques et environnementaux de la santé. Il vise également à inclure les considérations en matière de santé dans les initiatives de développement économique, d'aménagement urbain et de revitalisation.

La quatrième phase du programme Villes-Santé du bureau régional de l'OMS pour l'Europe vient juste de prendre fin (2003–2008). Les villes participant au réseau de cette quatrième phase étaient concentrées sur trois thèmes centraux : le vieillissement en bonne santé, l'aménagement urbain sain et l'évaluation des effets sanitaires. De plus, toutes les villes participantes mettaient l'accent sur l'activité physique et la vie active. La Phase V a aujourd'hui commencé (2009–2013).

Le thème dominant de la Phase V est la santé et l'équité en santé dans toutes les politiques locales. « La santé dans toutes les politiques » découle de la reconnaissance que la santé de la population n'est pas seulement un produit des activités du secteur de la santé, mais qu'elle est largement déterminée par les politiques et les politiques qui transcendent le secteur de la santé. Dans le cadre du lancement de la Phase V, les maires et les dirigeants municipaux européens qui sont membres du réseau Villes-Santé se sont engagés à travailler à la promotion de la santé, à prévenir les maladies et les déficiences, et à prendre systématiquement des mesures contre l'inégalité au niveau municipal. Les dirigeants municipaux seront les défenseurs et les gardiens de la santé de leurs citoyens³⁰.

³⁰ Cette section sur le mouvement mondial est largement fondé sur l'information contenue dans le site www.euro.who.int/healthy-cities

Annexe 3 : Intervenants clés

- Paul Born, Président, formateur et conseiller stratégique, Tamarack – Un Institut qui prône la mobilisation communautaire, Waterloo, Ontario
- Joey Edwardh, Directeur exécutif, Community Development Halton, Burlington Ontario
- Ron Labonté, Chaire de recherche du Canada sur la mondialisation contemporaine et l'égalité en matière de santé, Institut de recherche sur la santé des populations, Université d'Ottawa
- Louise Potvin, Chaire de la FCRSS sur les approches communautaires et les inégalités en matière de santé, Département de médecine sociale et préventive, Université de Montréal
- Lorraine Thompson, Lorraine Thompson Information Services Limited, Regina, Saskatchewan
- Sherri Torjman, Vice-présidente, Caledon Institute of Social Policy, Ottawa, Ontario

LISTE DES TÉMOINS

39 ^e législature, 1 ^{re} session		
ORGANISATION	NOM / TITRE	DATE DE COMPARUTION
Commission des déterminants sociaux de la santé de l'Organisation mondiale de la santé	L'honorable Monique Bégin, C.P., commissaire	22-02-2007
Institut de recherche sur la santé des populations	Ronald Labonté, Chaire de recherche du Canada sur la mondialisation contemporaine et l'égalité en matière de santé	28-02-2007
Régie provinciale des Services de santé de la C.-B.	Dr. John Millar, directeur général, Surveillance de la santé des populations et contrôle des maladies	28-02-2007
School of Health Policy and Management - Université York	Dennis Raphael, professeur	28-02-2007
Agence de la santé publique du Canada	Jim Ball, directeur, Division du développement et des partenariats, Direction des politiques stratégiques, Direction générale des politiques stratégiques, des communications et des services généraux D ^e Sylvie Stachenko, administrateur en chef adjointe de la santé publique, Direction générale de la promotion de la santé et de la prévention des maladies chroniques	21-03-2007
Kunin-Lunenfield Applied Research Centre	Sholom Glouberman, scientifique associé	21-03-2007
Agence de la santé publique du Canada	Maura Ricketts, directrice générale par intérim, Bureau de la pratique en santé publique, Pratique en santé publique et opérations régionales	21-03-2007
Statistique Canada	Michael Wolfson, statisticien en chef adjoint, Analyse et Développement	21-03-2007
Kunin-Lunenfield Applied Research Centre	Sholom Glouberman, scientifique associé	21-03-2007
Institut de la santé publique et des populations	D ^e John Frank, directeur scientifique, Instituts de recherche en santé du Canada	28-03-2007

Santé et politiques sociales dans le monde	D ^r . Jody Heymann, Chaire de recherche du Canada sur la santé et les politiques sociales dans le monde	28-03-2007
Université McGill	D ^r . John Lynch, Chaire de recherche du Canada en santé des populations	28-03-2007
Agence de la santé publique du Canada	Jim Ball, directeur, Division du développement et des partenariats, Direction des politiques stratégiques	25-04-2007
Affaires indiennes et du Nord Canada	Marc Brooks, directeur général, Direction générale du développement communautaire, secteur des politiques socio-économiques et opérations régionales	25-04-2007
Centre de recherche sur la santé des Autochtones, Université du Manitoba	John O'Neil, professeur et directeur	25-04-2007
Santé Canada	Ian Potter, sous-ministre adjoint, Direction générale de la santé des Premières Nations et des Inuits	25-04-2007
Institut de la santé des Autochtones (ISA) pour l'Institut de la santé des Autochtones des IRSC	Dr Jeff Reading, directeur scientifique	25-04-2007
Faculté de recherche/Saskatchewan Population Health and Evaluation Research Unit	Sylvia Abonyi, Chaire de recherche pour la santé des Autochtones au Canada	02-05-2007
Organisation nationale de la santé autochtone (ONSA)	Mark Buell, gestionnaire, Politiques et communications Carole L. Lafontaine, directrice générale intérimaire	02-05-2007
Université de la Colombie-Britannique - Département de psychologie	Michael J. Chandler, professeur à l'Université de la Colombie-Britannique et chercheur émérite des Instituts de recherche en santé du Canada et de la Fondation Michael-Smith pour la recherche en santé	02-05-2007
Université de Toronto	D ^r Kue Young, professeur, Département des services de santé publique	02-05-2007
Observatoire Vieillesse et Société (OVS)	D ^r André Davignon, fondateur	16-05-2007

Ministère de la Santé de la Nouvelle-Écosse	Valerie J. White, directrice exécutive, Secrétariat des aînés	16-05-2007
Agence de la santé publique du Canada - Division du vieillissement des aînés	Margaret Gillis, directrice	16-05-2007
Association canadienne de gérontologie	Mark Rosenberg, professeur à l'Université Queen's	16-05-2007
The CHILD Project	Dr Hillel Goelman, directeur, Senior Scholar, Human Early Learning Partnership (HELP)	30-05-2007
Instituts de recherche en santé du Canada	Dr Michael Kramer, directeur scientifique, Institut du développement et de la santé des enfants et des adolescents	30-05-2007
Council of Early Child Development	Stuart Shankar, professeur, président	30-05-2007
Fondation des Métis du Manitoba	D ^r Judy Bartlett, directrice du Centre autochtone de la santé et du bien-être et professeure agrégée, Département des sciences de la santé communautaire, Faculté de médecine, Université du Manitoba	31-05-2007
Ralliement national des Métis	David Chartrand, ministre de la Santé Marc LeClair, conseiller national du ministre de la Santé Rosemarie McPherson, porte-parole national des femmes de la Nation métisse	31-05-2007
Ministère de la Santé de la C.-B.	D ^r Evan Adams, médecin-conseil en santé autochtone, Bureau du médecin-hygiéniste en chef	01-06-2007
Fondation des Métis du Manitoba	D ^r Judy Bartlett, directrice du Centre autochtone de la santé et du bien-être et professeure agrégée, Département des sciences de la santé communautaire, Faculté de médecine, Université du Manitoba	01-06-2007
Institut de la santé des Autochtones	Laura Commanda, directrice adjointe, Partenariats, applications des connaissances et des relations internationales	01-06-2007

Pauktuutit Inuit Women of Canada	Jennifer Dickson, directrice générale	01-06-2007
Association des femmes autochtones du Canada	Claudette Dumont-Smith, conseillère principale en santé	01-06-2007
Indigenous People's Health Research Centre	Willie Ermine, professeur, auteur-éthicien	01-06-2007
Inuit Tapiriit Kanatami	Anna Fowler, coordonnatrice de projets, ministère de la Santé	01-06-2007
Association nationale des centres d'amitié	Alfred J. Gay, analyste des politiques	01-06-2007
Assemblée des Premières Nations	Valerie Gideon, directrice de la Santé et du Développement social	01-06-2007
Université de l'Alberta	Malcom King, professeur, Faculté de médecine	01-06-2007
Association des infirmières et infirmiers autochtones du Canada	Julie Lys, directrice, Région des Territoires du Nord-Ouest	01-06-2007
Université de Toronto	Chandrakant P. Shah, professeur émérite	01-06-2007
Congrès des Peuples Autochtones	Erin Wolski, coordonnatrice des programmes de politique sanitaire	01-06-2007
39^e législature, 2^e session		
Ministère de la Santé et des Affaires sociales	Irene Nilsson-Carlsson, directeur général adjoint, Division de la santé publique	22-11-2007
Institut national de santé publique de Suède	Dr. Gunnar Agren, directeur général Bernt Lungren, spécialiste des politiques de santé publique	22-11-2007
Institut Karolinska, Département des services de santé publique	Dr. Piroska Ostlin, chercheur principal	22-11-2007
The Quaich Inc.	Patsy Beattie-Huggan, présidente	28-11-2007
Université McMaster	John Eyles, professeur, École de géographie et des sciences de la Terre	28-11-2007
Ministère de la Santé de l'Île-du-Prince-Édouard	Teresa Hennebery, sous-ministre adjointe, Secteur opérationnel	28-11-2007
Groupe d'étude sur les politiques et la santé	France Gagnon, professeure et codirectrice	05-12-2007
Université de Montréal	Nicole Bernier, professeure adjointe	05-12-2007

Ministère de la Santé du Royaume-Uni	Dr. Fiona Adshead, directrice générale, Amélioration de la santé	11-12-2007
Autorité sanitaire du district intérieur de la C.-B.	Lex Baas, directeur de la santé des populations	12-12-2007
Université de la Colombie-Britannique	James Frankish, professeur et directeur de programme	12-12-2007
Ministère de la Promotion de la santé de l'Ontario	Pegeen Walsh, directrice, Prévention des maladies chroniques	06-02-2008
Réseau d'intégration des services de santé de Toronto	Laura Pisko-Bezruchko, directrice principale de la planification	06-02-2008
Institut de cardiologie de l'Université d'Ottawa	D ^r . Andrew Pipe, directeur médical, Centre de prévention et réadaptation	06-02-2008
Institut canadien d'information sur la santé	Glenda Yeates, présidente-directrice générale Keith Denny, gestionnaire intérimaire	13-02-2008
Université du Manitoba	Noralou Roos, professeur, Faculté de médecine	13-02-2008
Agence de la santé publique du Canada	Jim Ball, directeur général, Direction des initiatives stratégiques et de l'innovation	27-02-2008
Conseil du Trésor du Canada	Sally Thornton, Affaires indiennes et Santé	27-02-2008
Finances Canada	Yves Giroux, directeur intérimaire, Politique sociale	27-02-2008
Université McMaster	D ^r Salim Yusuf, professeur, Département de médecine	02-04-2008
Université McMaster	D ^r Sonia Anand, professeure agrégée, Département de médecine	09-04-2008
Université Queen's	Karen Hitchcock, directrice et vice-chancelière Kristan Aronson, professeur d'épidémiologie	09-04-2008
Commission des déterminants sociaux de la santé de l'Organisation mondiale de la Santé	L'honorable Monique Bégin, commissaire	18-04-2008
Université McMaster	Gina Browne, professeure en sciences infirmières et épidémiologie clinique	18-04-2008

Agence de la santé publique du Canada	D ^r David Butler-Jones, administrateur en chef de la santé publique du Canada	18-04-2008
Institut de recherche en politiques publiques	Mel Cappe, président	18-04-2008
À titre personnel	Laura Corbett, consultante David Dodge, ancien gouverneur de la Banque du Canada Beverly Nickoloff, consultante John Wright, ancien sous-ministre, ministère des Finances et ministère de la Santé	18-04-2008
Access Consulting	Steven Lewis, consultant	18-04-2008
Association canadienne de santé publique	Debra Lynkowski, directrice générale	18-04-2008
Conference Board du Canada	Diana MacKay, directrice associée, Éducation et apprentissage	18-04-2008
Réseaux canadiens de recherche en politiques publiques	Sharon Manson Singer, présidente	18-04-2008
Université Dalhousie	Lars Osberg, Département d'économie	18-04-2008
Université de Montréal	Louise Potvin, professeure, Département de médecine sociale et préventive	18-04-2008
Institut de santé des Autochtones pour les Instituts de recherche en santé du Canada	D ^r Jeff Reading, directeur scientifique	18-04-2008
Association médicale canadienne	William Tholl, secrétaire général	18-04-2008
Centre canadien de politiques alternatives	Armine Yalnizyan, économiste principale	18-04-2008
Centre canadien d'information sur la santé (ICIS)	Glenda Yeates, présidente-directrice générale	18-04-2008
Statistique Canada	Michael Wolfson, statisticien en chef adjoint, Analyse et Développement	30-04-2008
Institut de la santé publique et des populations	D ^r John Frank, directeur scientifique, IRSC	30-04-2008
Ressources humaines et Développement social Canada	Cliff Halliwell, directeur général, Direction de la recherche en politiques stratégiques	30-04-2008

Affaires indiennes et du Nord Canada	Marc Brooks, directeur général, Direction du développement communautaire, Politiques socioéconomiques et opérations régionales	30-04-2008
Centre de collaboration nationale des déterminants de la santé	Hope Beanlands, directrice scientifique	07-05-2008
Centre de collaboration nationale en politiques publiques et santé	François Benoit, directeur scientifique	07-05-2008
Centre de collaboration nationale en santé environnementale	D' Ray Copes, directeur scientifique	07-05-2008
Centre de collaboration nationale de la santé autochtone	Margo Greenwood, directrice scientifique	07-05-2008
Fédération canadienne des municipalités	Michel Frojmovic, directeur, Consultation et recherche Acacia	14-05-2008
Conseil canadien de développement social	Pat Steenberg, coordonnatrice, Stratégie d'accès communautaire aux statistiques	14-05-2008
Fondation Atkinson	Lynne Slotek, directrice nationale du projet, Index canadien du bien-être	14-05-2008
Régie provinciale des Services de santé de la C.-B.	D' John Millar, directeur général, Surveillance de la santé des populations et contrôle des maladies	14-05-2008
Ministère des Finances de Terre-Neuve-et-Labrador	Alton Hollett, sous-ministre adjoint, Direction de l'économie et de la statistique Robert Reid, cadre supérieur, SESA, Direction de l'économie et de la statistique	20-05-2008
Université Memorial de Terre-Neuve	Roy West, professeur émérite d'épidémiologie	20-05-2008
	Shawn Skinner, ministre des Ressources humaines, du Droit du travail et de l'Emploi, Terre-Neuve-et-Labrador	20-05-2008
Ministère des Ressources humaines, du Droit du travail et de l'Emploi de Terre-Neuve-et-Labrador	Lynn Vivian-Book, sous-ministre adjointe, Revenu, emploi et services à la jeunesse Aisling Gogan, directrice, Stratégie de réduction de la pauvreté	20-05-2008
Ministère de la Santé et des Services communautaires de Terre-Neuve-et-Labrador	Eleanor Swanson, directrice, Équipe du mieux-être	20-05-2008

Conseil des services communautaires de Terre-Neuve-et-Labrador	Darlene Scott, adjointe de programme principale Peggy Matchim, coordonnatrice, Vibrant Communities	20-05-2008
Ministère de la Santé et des Services communautaires de Terre-Neuve-et-Labrador	Joy Maddigan, sous-ministre adjointe	21-05-2008
Ministère des Ressources humaines, du Droit du travail et de l'Emploi de Terre-Neuve-et-Labrador	Aisling Gogan, directrice, Stratégie de réduction de la pauvreté	21-05-2008
Secrétariat rural, conseil exécutif	Gerald Crane, directeur, du Partenariat rural canadien, Recherche et analyse rurales	21-05-2008
GRC, Planification générale et services à la clientèle, Terre-Neuve-et-Labrador	Sergent Doug Ross, sous-officier responsable	21-05-2008
Eastern Health	Lisa Browne, spécialiste de la planification	21-05-2008
Kids Eat Smart Foundation	Susan Green, consultante	21-05-2008
Capital Coast Development Alliance	Christine Snow, directrice exécutive	21-05-2008
Ministère des Finances de Terre-Neuve-et-Labrador	Alton Hollett, sous-ministre adjoint, Direction de l'économie et de la statistique	21-05-2008
Association canadienne pour les Nations Unies	Kathryn White, directrice générale	28-05-2008
Société des obstétriciens et gynécologues du Canada	D ^r André Lalonde, vice-président général	28-05-2008
Société canadienne de pédiatrie	Marie Adèle Davis, directrice générale	28-05-2008
Université de Victoria	Marcia Hills, directrice, Centre de recherche en promotion de la santé communautaire	05-06-2008
Université Laval	Maria De Koninck, professeure titulaire, Département de médecine sociale et préventive	05-06-2008
Ministère de la Santé et des Soins de longue durée de l'Ontario	Richard Prial, directeur, Direction de l'harmonisation stratégique	05-06-2008

A titre personnel	L'honorable Carolynne Bennett, C.P., députée, ancienne ministre d'État (Santé publique)	11-06-2008
Université de l'Alberta	Deanna Williamson, professeure associée, Faculté d'écologie humaine	11-06-2008
Région sanitaire de Saskatoon	D' Cordell Neudorf, administrateur en chef de la santé publique, Services de santé publique	11-06-2008
Agence canadienne d'évaluation environnementale	John Smith, directeur, Affaires législatives et réglementaires Tim Smith, conseiller principal en matière de politiques	18-06-2008
Centre de collaboration nationale – Politiques publiques et santé	Louise Saint-Pierre, chef de projet	18-06-2008
40^e législature, 2^e Session		
Institut de recherche en politiques publiques	Mel Cappe, président	26-02-2009
Le Cercle Sussex	Jim Mitchell, partenaire fondateur	26-02-2009
A titre personnel	D' Trevor Hancock, consultant en promotion de la santé	05-03-2009
Accord de Vancouver	Christine Lattey, coordonnatrice exécutive	05-03-2009
Diversification de l'économie de l'Ouest du Canada	Michelle Neilly, directrice générale, Opérations C.-B.	05-03-2009
Université Western Ontario	Neil Bradford, professeur agrégé de sciences politiques, Collège universitaire Huron	05-03-2009
Conseil canadien de développement social	Katherine Scott, vice-présidente, recherche	12-03-2009
Institut Wellesley	Bob Gardner, directeur, politiques et recherche	12-03-2009
Nexus Santé	Connie Clement, directrice générale	12-03-2009
Assemblée des Premières Nations	Rose Sones, directrice adjointe, Politiques stratégiques, Secrétaire à la santé et au développement social Gina Doxtator, analyste des politiques de santé	25-03-2009

Inuit Tapiriit Kanatami	Elizabeth Ford, directrice du Service de la santé et de l'environnement Rosemary Cooper, directrice des services à la haute direction	25-03-2009
Association des femmes autochtones du Canada	Erin Wolski, directrice de la santé	25-03-2009
Organisation nationale de la santé autochtone	Paulette Tremblay, directrice générale	25-03-2009
Ralliement national des Métis	Barbara Van Haute, directrice, Élaboration des programmes	25-03-2009
Assemblée des Premières Nations	Bob Watts, directeur général	25-03-2009
Inuit Tapiriit Kanatami	Rosemary Cooper, directrice des services à la haute direction	25-03-2009
Métis Nation – Saskatchewan	Robert Doucette, président	25-03-2009
Affaires indiennes et du Nord Canada	Mary Quinn, directrice générale, Direction générale de la politique sociale et des programmes	26-03-2009
Association des infirmières et infirmiers autochtones du Canada	Rosella Kinoshameg, présidente	26-03-2009
National Association of Friendship Centres	Peter Dinsdale, directeur exécutif	26-03-2009
Organisation nationale des représentants indiens et inuit en santé communautaire	Debbie Dedam-Montour, directrice exécutive	26-03-2009
Santé Canada	Kathy Langlois, directrice générale, Programmes communautaires, Santé des Premières nations et des Inuits Catherine Lyons, directrice générale, Santé des Premières nations et des Inuits Shelagh Jane Woods, directrice générale, Soins de santé primaires et santé publique, Santé des Premières nations et des Inuits	26-03-2009
Université de Victoria	D ^r Jeff Reading, professeur et directeur, Centre de recherche sur la santé des autochtones	26-03-2009
Acacia Consulting and Research	Michel Frojmovic, directeur	27-03-2009

Agence de la santé publique du Canada	D ^r Gregory Taylor, directeur général, Bureau de la pratique en santé publique	27-03-2009
Agence ontarienne de protection et de promotion de la santé	D ^r Vivek Goel, président-directeur général	27-03-2009
Agriculture et Agroalimentaire Canada	Christine Burton, directrice, Politique rurale et développement stratégique	27-03-2009
Inforoute Santé du Canada Inc.	Mike Sheridan, chef de l'exploitation	27-03-2009
Institut canadien d'information sur la santé	Jean Harvey, directrice, Initiative sur la santé de la population canadienne Jean-Marie Berthelot, vice-président, Programmes	27-03-2009
Ministère des Finances de Terre-Neuve-et-Labrador	Alton Hollett, sous-ministre adjoint, Direction de l'économie et des statistiques	27-03-2009
Régie régionale de la santé de Saskatoon	D ^r Cordell Neudor, médecin-hygiéniste en chef	27-03-2009
Santé Canada	Karen Dodds, sous-ministre adjointe	27-03-2009
Statistique Canada	Michael Wolfson, statisticien en chef adjoint	27-03-2009
Université du Manitoba	Mark Smith, directeur agrégé, Manitoba Centre for Health Policy (Repository)	27-03-2009
Bande de Seabird Island	Carlene Brown, directrice de service de garderie Cheryl Suave, employée Fallon Ludman, parent Bonnie Nickel, parent Carolyne Neufeld, directrice de santé Steven McKinnon, technicien	27-03-2009
A titre personnel	D ^r Kellie Leitch	01-04-2009
BC Healthy Communities	Jodi Mucha, directrice	01-04-2009
Réseau local d'intégration des services de santé de Champlain	D ^r Robert Cushman, directeur général	01-04-2009



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WITNESSES

Wednesday, April 1st, 2009

Champlain Local Health Integration Network:

Dr. Robert Cushman, Chief Executive Officer.

BC Healthy Communities:

Jodi Mucha, Director.

As an individual:

Dr. Kellie Leitch.

TÉMOINS

Le mercredi 1^{er} avril 2009

Réseau local d'intégration des services de santé de Champlain :

Dr Robert Cushman, directeur général.

BC Healthy Communities :

Jodi Mucha, directrice.

À titre personnel :

Dre Kellie Leitch.



